

Nicola Redmond L.C.P.H MARH RHom

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Patient Questionnaire

This form is for information, which will help analyse your problems and manage your treatment. Please fill it in as completely as possible. All the information will be kept strictly confidential and secure.

NAME:

NAME OF PARENT/s IF PATIENT IS A CHILD:

ADDRESS:

.....POSTCODE.....

TEL NO - home TEL NO - mobile

EMAIL add

FEMALE/MALE D.O.B: BIRTH PLACE NATIONALITY:

HEIGHT: WEIGHT: AGE: MARITAL STATUS:

GP's PRACTICE NAME & CONTACT NO:

OCCUPATION:

How did you hear about me? Friend Family Web search Other

(Please specify)

Your Rights:

Please note that this information will not be processed, passed on to any other agency, will not be used for purposes other than the specific and explicit promotion of your health and only in connections with my clinic. Your statutory rights will not be violated or diluted in any way whatsoever. In order to record details in connection with the diagnosis of your problems your information may be held on a computer. You may ask to see it at any time.

Consent:

I confirm that I request Homeopathic treatment from Nicola Redmond. I understand that this does not imply a promise of cure.

Signature:

(of parent if patient is a child)

Date:

Previous Illnesses:

Chicken Pox	<input type="checkbox"/>
Measles	<input type="checkbox"/>
German Measles	<input type="checkbox"/>
Mumps	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>
Scarlet Fever	<input type="checkbox"/>
Scarletina	<input type="checkbox"/>
Shingles	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>
Ear Infections or Glue Ear	<input type="checkbox"/>
Tonsilitis	<input type="checkbox"/>
Glandular Fever	<input type="checkbox"/>
Any other illnesses, including severe viral infections, state age/s & duration.		

Age:

Vaccinations: ✓ *the Reaction box if adverse reaction*

		Reaction	Age
DPT	<input type="checkbox"/>	<input type="checkbox"/>
(diphtheria, whooping cough & tetanus)			
Polio	<input type="checkbox"/>	<input type="checkbox"/>
MMR	<input type="checkbox"/>	<input type="checkbox"/>
(measles, mumps & rubella)			
Measles (single)	<input type="checkbox"/>	<input type="checkbox"/>
Rubella (single)	<input type="checkbox"/>	<input type="checkbox"/>
HIB (meningitis)	<input type="checkbox"/>	<input type="checkbox"/>
Meningitis C	<input type="checkbox"/>	<input type="checkbox"/>
BCG (tuberculosis)	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Others, including travel vaccs (eg Hepatitis A, Typhoid, Yellow Fever, Cholera,) State age & if any adverse reaction :			

Exercise: Indicate if you do any exercise, walking, gym, swimming etc & frequency, or if difficult to achieve any exercise for any reason.

How many coughs or colds (*if any*) do you get during the year & at what time of the year? Are there other triggers apart from weather/season changes?

Average energy levels 1-10:(1=LOW, 10=HIGH) & what time/s are your energy slumps. Is your energy better in the day or at night.

Memory/concentration 1-10:(1=weak, 10=strong)

Perspiration: 1-10:(1=little, 10=profuse)

Blood Type:

Blood Pressure:

Cholesterol:

Please list any allergies/intolerances including any hayfever symptoms, catarrh, sinus infections, giving times of year that are significant & any other information:

Please list any **medication** that you are currently taking (including contraception pill, vitamins, herbs
Also list any recreational drugs used either currently or in the past, with dates if possible)

Name of drug/medication	When started	Dosage & Frequency

Please list any **current treatments/therapies** (including Hospital treatment or alternative health treatment

ACCIDENTS: Note any serious and those which you feel are important, & what age/s., include any falls, or head injuries.

SURGICAL PROCEDURES/MAJOR DENTAL WORKS: State if anesthesia was necessary, & what age/s.

PRE-BIRTH: Any emotional or physical problems experienced by your mother during pregnancy.

BIRTH: Type of labour.

FAMILY HEALTH HISTORY: Please give brief details of the health history (past & present) of your **blood** relatives. Eg: *Diabetes, heart disease, birth defects, disabilities or handicaps, cancer, tuberculosis, arthritis, thyroid, behavioural problems, suicide, alcoholism, etc*

<i>Father's side</i>		<i>Mother's side</i>	
<i>Grandfather</i>	<i>Grandmother</i>	<i>Grandfather</i>	<i>Grandmother</i>
<i>Father</i>	<i>Aunt/s</i>	<i>Mother</i>	<i>Aunt/s</i>
<i>Uncle/s</i>	<i>Cousin/s</i>	<i>Uncle/s</i>	<i>Cousin/s</i>
<i>Sister/s Brother's</i>		<i>Any other family health history that you know of:</i>	
<i>Children</i>			

SKIN: Please note if you have/had any of the following or other skin complaints and at what age/s & duration. *Warts, verrucae, herpes (cold sores), abscesses, boils, moles, eczema, impetigo etc*

WEATHER, ENVIRONMENT, EMOTIONS REACTIONS

Cold Heat Wind Drafts Damp Humidity Sun Rain Indoors Outdoors
For the above please: Put a ✓ = Better for Put a X = Worse for (leave blank if not a strong reaction)

Does change of weather affect you/your symptoms, ie change of seasons, storms, moon changes?

Are you normally a chilly or a warm person in general (despite the weather)?

Sea Mountains City Countryside Being on your own Being in company
Put a ✓ = Better for Put a X = Worse for (leave blank if not a strong reaction)

Physical exertion Dancing Resting
In general, please indicate ✓ = Better for X = Worse for (leave blank if not a strong reaction)

When something upsets you do you seek company or do you prefer to be alone?

What would make you cry?

What do you most love to do?

SHOCKS/TRAUMAS: Anything which may have affected your mental, emotional or physical wellbeing, & at what age/s. If you are not able to specify, please just write Trauma and indicate 1-10 to indicate intensity (*1=low,10=high*)

FEARS & PHOBIAS: Eg heights, closed spaces, dark, germs, ghosts, animals, insects, snakes, spiders, storms, examinations, disease, death/dying, poverty, failure etc. This should be **a significant fear/phobia.**

DREAMS: Any dreams that stay in your memory. Any recurring dreams. Include childhood dreams. Please try to recall at least one dream that you have had in your life. You do not have to put a lot of detail, notes will be fine

APPETITE: Indicate any of the following descriptions which apply, beside the item. You may want to put more than one description alongside a food item (eg. you might love cream but it aggravates you.) State your preferences regardless of your 'normal' diet and regardless of what you feel may be 'right' or 'wrong'. **Only when STRONGLY indicated.**

Hate Love Crave Allergic Agg (aggravates) Better (for)

beef		lamb		pork		chicken	
meat fat		smoked meats		bacon		fried	
fish		seafood		cheese		butter	
hot spicy		salty		vinegar(y)		pickles	
eggs		vegetables		salad		potatoes	
pasta		rice		bread		rich food	
cream		milk		yoghurt		mayonnaise	
wine		beer		spirits (ie vodka,gin etc)		tobacco	
tea		coffee		ice cream		Cakes/puddings/biscuits	
raw food		sweets		pepper		chocolate	
fruit		citrus fruits		condiments		mayonnaise	
cold drinks		warm drinks		cold food		warm food	

Any other food or drink items not here that you feel strongly about:

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