

# Nicola Redmond

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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:**

**Age:**

- Chicken Pox  .....
- Meningitis  .....
- Scarlet Fever  .....
- Scarletina  .....
- Whooping Cough  .....
- Ear Infections or Glue Ear  .....
- Tonsilitis  .....

Any other illnesses, including severe viral infections, state age/s & duration.

**Vaccinations:** ✓ the Reaction box if adverse reaction

	Reaction	Age
DPT (diphtheria, whooping cough & tetanus)	<input type="checkbox"/>	.....
Polio	<input type="checkbox"/>	.....
MMR (measles, mumps & rubella)	<input type="checkbox"/>	.....
Measles (single)	<input type="checkbox"/>	.....
Rubella (single)	<input type="checkbox"/>	.....
HIB (meningitis)	<input type="checkbox"/>	.....
Meningitis C	<input type="checkbox"/>	.....
BCG (tuberculosis)	<input type="checkbox"/>	.....
Tetanus	<input type="checkbox"/>	.....

**Please list any allergies or intolerances:**

Please list any current **medication**.

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

**PRE-BIRTH:** Any emotional or physical problems experienced during pregnancy.

**BIRTH:** Type of labour and duration

**FAMILY HEALTH HISTORY:** Please give brief details of the health history (past & present) of your child's **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>	