





Please list any **medication** that you are currently taking (including contraception pill, vitamins, herbs)

Name of drug/medication	When started	Dosage & Frequency

**USE OF DRUGS:** Any history of heavy or prolonged use - both recreational and prescribed.

Name of drug/medication	When started	Dosage & Frequency

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

**ACCIDENTS:** Note any serious and those which you feel are important, & what age/s.

**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>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)*

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

How do thunderstorms affect you?

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.

**FEARS & PHOBIAS:** Eg heights, closed spaces, dark, germs, ghosts, animals, insects, snakes, spiders, storms, examinations, disease, death/dying, poverty, failure etc.

**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		beef		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		Cakes/puddings /biscuits		ice cream		coffee	
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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