Streatham Wells Therapies

Confidential Consultation Record

Client name:	**Date:**
Address:	**Telephone:**
	Email:
Postcode:	

DoB:	**Gender:**	**Height:**	**Weight:**

GP name and surgery:	**Emergency contact details:**
	Name:
	Relationship:
	Contact number:

Medical history:

Hospital visits / Operations (with dates)	**Accidents / Injuries (with dates)**
Date last visited GP:	**Current medication (inc. over the counter):**
Reason:	

Females only:

Pregnant:	Yes / No	PMT:	Yes / No
Regular periods:	Yes / No	Menopause:	Yes / No
Date of last period:		Hysterectomy:	Yes / No

Personal and close family medical history (blood relatives only)

Vascular	None	Heart	BP (H/L)	Circulation	Thrombosis	Varicose veins
Endocrine / Immune	None	Diabetes	Thyroid	ME	Lupus (SLE)	HIV
Nervous	None	Epilepsy	Depression	Migraines	MS	Headaches
Digestion	None	IBS	Constipation	Ulcers	Colitis	Diarrhoea
Respiratory	None	Asthma	Bronchiitis	Sinusitus		
Skin	None	Eczema	Psoriasis	Athlete's foot	Verrucae	
Genito / Urinary	None	Kidney	Bladder	Infertility		
Other	None	Arthritis	Rheumatism	Hepatitis	Allergies	

Currently suffering from any infectious conditions? **Yes / No**

Details:

Currently undergoing other alternative therapy? **Yes / No**

Details:

Lifestyle Questionnaire

Smoke:	Yes / No	Number / Day	**Regular meals:**	Yes / No
Drink alcohol:	Yes / No	Units / Week	**Balanced diet:**	Yes / No
Caffeinated drinks:	Yes / No	Number / Day	**Eat before bed:**	Yes / No
Water:	Yes / No	Amount / Day	**Eat between meals:**	Yes / No

Occupation:		**Work hours / Pattern:**	

Family status:	Single / Partnered / Children / Carer		
Exercise:	Daily / Weekly / Infrequently / Never	**Type:**	
Sleep:	Well / Poorly / Restlessly / During daytime	**Anxieties:**	Yes / No
Stress:	None / Some / Extreme	**Depression:**	Yes / No

If suffering from stress what are the current main causes?:

Additional information / Comments:

Declaration

The information I have given about my general health in this consultattion is true to the best of my knowledge and belief, and I hereby give my consent to ** myself / ** my child being treated by natural therapy.

** - delete as appropriate

Signed:

Date:

Therapist: