Health Questionnaire

General Information

Name ______________________ Date of Birth ______________________

Address ______________________ GP Name ______________________

Postcode ______________________ Surgery ______________________

Tel __________ Mobile __________

Email ______________________

Occupation ______________________

Number of children:

☐Married ☐Partner ☐ Single
☐Divorced ☐Widowed ☐Other

Presenting Symptoms

Reason for seeking treatment today: ______________________

Please tick the box and/or circle any **persistent** symptoms you have had in the **past few months**. Read through every section and tick "no problems" if none of the symptoms apply to you.

General
- ☐ Unexplained weight loss / gain
- ☐ Unexplained fatigue / weakness
- ☐ Poor appetite / eating disorders
- ☐ Fall asleep during day when sitting
- ☐ Fever, chills
- ☐ **No problems**

Skin
- ☐ New or change in mole
- ☐ Itching
- ☐ Eruptions / rash
- ☐ **No problems**

Allergic/Immune
- ☐ Hay fever / allergies
- ☐ Frequent infections
- ☐ Food sensitivities
- ☐ Hives
- ☐ **No problems**

Breast
- ☐ Breast lump / pain / nipple discharge
- ☐ **No problems**

Ears/Nose/Throat
- ☐ Nosebleeds, trouble swallowing
- ☐ Frequent sore throat, hoarseness
- ☐ Hearing loss / ringing in ears / ear pain
- ☐ **No problems**

Cardiovascular
- ☐ Chest pain / discomfort
- ☐ Palpitations (fast or irregular heartbeat)
- ☐ **No problems**

Respiratory
- ☐ Cough / wheeze
- ☐ Loud snoring / altered breathing during sleep
- ☐ Short of breath with exertion
- ☐ **No problems**

Gastrointestinal
- ☐ Heartburn / reflux / indigestion
- ☐ Blood or change in bowel movement
- ☐ Constipation
- ☐ Diarrhoea
- ☐ **No problems**

Genitourinary
- ☐ Leaking urine
- ☐ Blood in urine / pain urinating
- ☐ Night time urination or increased frequency
- ☐ Discharge: penis or vagina
- ☐ Concern with sexual function
- ☐ **No problems**

Musculoskeletal
- ☐ Neck pain
- ☐ Back pain
- ☐ Muscle / joint pain
- ☐ **No problems**

Endocrine
- ☐ Heat or cold sensitivity
- ☐ Unstable blood sugar
- ☐ Diminished sex drive
- ☐ Unwanted hair
- ☐ **No problems**

Hematologic/Lymphatic
- ☐ Swollen glands
- ☐ Easy bruising
- ☐ **No problems**

Neurological
- ☐ Headache
- ☐ Memory loss
- ☐ Fainting
- ☐ Dizziness
- ☐ Numbness / tingling
- ☐ Unsteady gait
- ☐ Frequent falls
- ☐ **No problems**

Eyes
- ☐ Change in vision / eye pain / redness
- ☐ **No problems**

Psychiatric
- ☐ Anxiety / stress / irritability
- ☐ Depression
- ☐ Hyperactivity
- ☐ Sleep problems / insomnia
- ☐ Nightmares
- ☐ Lack of concentration
- ☐ Poor memory
- ☐ **No problems**

Women only
- ☐ Pre-menstrual symptoms (bloating cramps, irritability)
- ☐ Problem with menstrual periods
- ☐ Hot flashes / night sweats
- ☐ **No problems**

TIME-LINE

Our life story provides useful information which can help direct a homeopath to the most relevant remedy for each individual. On looking at our biographical milestones in chronological order, patterns can emerge and sometimes a realisation that perhaps we have never been quite well since a certain event or experience.

In order to explore this, please complete the form overleaf in brief, making sure to include:

- Major illnesses, including childhood diseases
- Accidents / injuries
- Hospital stays
- Medical treatments / surgical procedures / major dental work, including chemotherapy, radiotherapy and anaesthetics
- Onset of long term prescriptions, including antibiotics, contraceptives, steroids, blood pressure medication, HRT, anti-depressants, sedatives, etc.
- Excessive or prolonged drug use, prescribed or recreational
- Significant shocks, traumas or experiences, including anything which may have had an impact on your mental, emotional or physical well-being
- Problems experienced by your mother during pregnancy, physical or emotional
- Information about your birth, including pain relief and any other interventions

If you are completing the form on behalf of a child, please fill in the details as if from their perspective.

TIME-LINE

	Age	Event & Comments (if needed)
Pre-birth (Pregnancy)		
Birth		
0-4		
5-10		
11-17		
18-21		
22-30		
30-40		
40-50		
50-60		
>70		

Please indicate if you or a relative have or have had any of the following conditions.

Condition	My Self	Mum	Dad	Siblings	Mum's mum	Mum's Dad	Dad's Mum	Dad's Dad	Other Relatives	Comments
ADD / ADHD										
Adrenal Disorders										
Alcohol / Drug abuse										
Allergy / Hay fever										
Alzheimer's Disease										
Anaemia										
Angina										
Anxiety										
Arthritis (Rheumatoid)										
Arthritis (Osteo)										
Asthma										
Bladder Problems										
Blood clot (leg)										
Blood clot (lung)										
Breast Lump (benign)										
Cancer Breast										
Cancer Colon										
Cancer Prostate										
Cancer Other Type										
Cataracts										
Colitis / Crohn's Disease										
Colon Polyp										
Coronary Artery Disease										
Croup										
Depression										
Diabetes (adult onset)										
Diabetes (juvenile onset)										
Diverticulitis										
Eczema										
Endometriosis										
Emphysema										
Epilepsy / Seizures										
Fibroids										
Fractures (broken bones)										
Gallbladder Disease										
Glandular Fever										
Glaucoma										
Gout										
Heart Attack										
Heart burn / Acid Reflux										
Hepatitis										
High Blood Pressure										
High Cholesterol										
Hip Fracture										

Condition	My Self	Mum	Dad	Siblings	Mum's mum	Mum's Dad	Dad's Mum	Dad's Dad	Other Relatives	Comments
HIV / Aids	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Disease / Failure	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Kidney Stones	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Liver Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Miscarriage	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Motor Neurone Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Osteoporosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Pneumonia	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Prostate Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Rheumatic Fever	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Chicken Pox / Shingles	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sinus Conditions	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Sleep Apnoea	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stomach Ulcers	☐	☐	☐	☐	☐	☐	☐	☐	☐	
STD	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Thyroid Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Tuberculosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Whooping Cough	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other:	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Childhood Conditions

Disease	Age	Disease	Age
☐ Chicken Pox		☐ Scarlet Fever	
☐ Measles		☐ Tuberculosis	
☐ Meningitis		☐ Whooping Cough	
☐ Mumps		☐ Frequent Antibiotics	
☐ Rubella		☐ Other	

Infant History

Pregnancy	Normal / Complications		
Delivery	Normal / Forceps / Vacuum / Caes		
Breast Fed	Y / N	Birth Weight	
Crawled	Early /Average / Late		
Walked	Early /Average / Late		
Talked	Early /Average / Late		

Immunisation History

Vaccine	Age	Vaccine	Age
HBV / Hep B (Hepatitis B)		PCV (Pneumococcal)	
MMR (Measles, Mumps, Rubella)		OPV (Oral Polio Vaccine)	
DTP / DTaP (Diphtheria, Tetanus, Pertussis)		HPV (Cervical Cancer)	
Varicella (Chicken Pox)		Other:	
HbCV / Hib (H. Influenza type b conjugate)			

Please list any adverse reactions:

Medications

Please include all current medications, supplements, herbs, homeopathic remedies, etc.

Medicine Name	Dose	Who prescribed it?	What do you take it for?

Please list any medicines / supplements to which you are allergic:

Lifestyle

Smoking	☐Yes ☐No	Approximately how many cigarettes a day do / did you smoke? When did you start smoking? When did you quit?
Alcohol	☐Yes ☐No	Approximately how many units of alcohol a week do / did you drink? Beer Wine Spirits
Drug Use	☐Yes ☐No	Please list:
Exercise	☐Yes ☐No	What kind of exercise? How much per week?
Diet	☐ Good ☐ Fair ☐ Poor	Please tick if you regularly eat / drink: ☐Red Meat ☐Poultry ☐Fish ☐Eggs ☐Dairy ☐Tofu ☐Nuts ☐Fruit ☐Vegetables ☐Pulses (Beans) ☐Whole Grains ☐Baked goods ☐ White Bread / Pasta / Rice ☐Sweets ☐Chocolate ☐Fried food ☐Water ☐Tea ☐Coffee ☐Herbal Tea ☐Fizzy drinks

Please list any food intolerances / allergies:

Terms and Conditions: I confirm that I have read the information on the Health Transitions website and that I understand and agree that Health Transitions offers an integrative and holistic approach to supporting health and encourages clients to seek independent medical advice and stay in close contact with their mainstream healthcare professionals. It is Health Transitions policy that should a client choose to withdraw from the use of prescribed medication while using holistic support, this should only be undertaken with the advice and supervision of their GP.

Cancellation Policy: I confirm that I understand and agree that any failure to attend an appointment or cancellation after 10.00 am on the previous working day (i.e. Friday for a Monday appointment) will require payment of the full consultation fee.

☐ Health Transitions periodically sends discounts and updates to existing clients. Please tick if you would like to be included.

NAME: Signature:

Date: (Parent / Guardian if under 16 years)