

**Foundation Assessment:Medical**

**Date \_\_\_\_\_\_\_\_\_**  **Surname\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Telephone**:**Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-mail address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Occupation** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Status** (married, single etc) **\_\_\_\_\_\_\_\_\_**

**Name of GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of GP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Weight\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CHIEF COMPLAINTS** :

**1.PLEASE LIST PRESENT SYMPTOMS IN ORDER OF PRIORITY (worst first):**

|  |  |  |
| --- | --- | --- |
| **Symptoms** | **Date started** | **Known triggering factors** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

# 2.FAMILY HISTORY Please indicate whether any family members currently or in the past have had any of the following:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Father** | **Mother** | **Father’s parents**  **Mother Father** | | **Mother’s parents**  **Mother Father** | | **Siblings** | **Children** |
| Heart disease |  |  |  |  |  |  |  |  |
| Respiratory disease |  |  |  |  |  |  |  |  |
| Stroke |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |
| M E / Chronic Fatigue |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |
| Hypertension (High BP) |  |  |  |  |  |  |  |  |
| Kidney disease |  |  |  |  |  |  |  |  |
| Reproductive issues |  |  |  |  |  |  |  |  |
| Mental illness |  |  |  |  |  |  |  |  |
| Alzheimer’s disease |  |  |  |  |  |  |  |  |
| Alcoholism |  |  |  |  |  |  |  |  |
| Parkinson’s |  |  |  |  |  |  |  |  |
| Other : |  |  |  |  |  |  |  |  |

**3.PAST MEDICAL HISTORY**

**Childhood** : Indicate if you have had any of the following childhood illnesses :

|  |  |  |
| --- | --- | --- |
| * Asthma | * Measles | * Rheumatic fever |
| * Chickenpox | * Mumps | * Scarlet fever |
| * Eczema | * Polio | * Whooping cough |
| * Frequent ear infections or colds | * Rubella (German measles) | * Other |

**Adulthood** (significant illnesses) prior to your current health circumstances

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Officially Diagnosed DISEASES** e.g. Diabetes Type 1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever had a genetic assessment done? Yes \_\_\_ No \_\_\_\_**

**4.TOP TO TOE CURRENT PHYSICAL AND EMOTIONAL SYMPTOMS**

**Rate each of the following symptoms based upon your current typical health profile by placing**

**a tick in the column against each symptom that you generally present with.**

|  |  |
| --- | --- |
| **Assessment region** | **Yes an Issue** |
| **MIND & EMOTIONS** |  |
| **Depression** |  |
| **Anxiety** |  |
| **Stressed** |  |
| **Fearful** |  |
| **Nervous** |  |
| **Angry** |  |
| **Aggressive** |  |
| **Irritable** |  |
| **Mood swings** |  |
| **Panic attacks** |  |
| **Feel an emotional numbness** |  |
| **Other** |  |
|  |  |
| **HEAD** |  |
| **Headaches** |  |
| **Migraines** |  |
| **Faintness/light headed feeling** |  |
| **Dizziness** |  |
| **Poor memory** |  |
| **Brain fog** |  |
| **Poor concentration** |  |
| **Difficulty making decisions** |  |
| **Stuttering or stammering** |  |
| **Slurred speech** |  |
| **Learning disabilities** |  |
| **Poor physical co ordination** |  |
| **Other** |  |
|  |  |
| **MOUTH** |  |
| **Pain** |  |
| **Lip ulcers** |  |
| **Tongue ulcers** |  |
| **Gum ulcers** |  |
| **Cold sores** |  |
| **Canker sores at side of mouth** |  |
| **Bleeding gums** |  |
| **Excess thirst** |  |
| **Other** |  |
|  |  |
| **EARS** |  |
| **Itchy** |  |
| **Earaches, recurrent infections** |  |
| **Drainage from the ear** |  |
| **Flaky skin** |  |
| **Blocked with wax** |  |
| **Other** |  |
|  |  |
| **NOSE** |  |
| **Sensitivity to chemical smells** |  |
| **Stuffiness in the nose** |  |
| **Sinus issues** |  |
| **Hay fever** |  |
| **Sneezing attacks** |  |
| **Other** |  |
|  |  |
| **EYES** |  |
| **Watery** |  |
| **Floaters** |  |
| **Itchy** |  |
| **Swollen/puffy** |  |
| **Reddened** |  |
| **Sticky** |  |
| **Dark circles under** |  |
| **Bags** |  |
| **Blurred vision** |  |
| **Tunnel vision** |  |
| **Partially sited** |  |
| **Other** |  |
|  |  |
| **THROAT** |  |
| **Pain** |  |
| **Swellings in neck/goitre** |  |
| **Chronic coughing** |  |
| **Gagging, need to clear mucous** |  |
| **Hoarseness** |  |
| **Loss of voice** |  |
| **Swallowing difficulties** |  |
| **Other** |  |
|  |  |
| **LUNGS** |  |
| **Chest congestion** |  |
| **Shortness of breath** |  |
| **Shallow breathing** |  |
| **Other** |  |
|  |  |
| **DIGESTIVE TRACT** |  |
| **Pain** |  |
| **Acute reflux/heartburn** |  |
| **Belching** |  |
| **Flatulence** |  |
| **Bloating** |  |
| **Herniation** |  |
| **Nausea** |  |
| **Vomiting regularly** |  |
| **Food intolerances** |  |
| **Food allergies** |  |
| **Craving sugar** |  |
| **Craving salt** |  |
| **Craving fats** |  |
| **Craving specific foods** |  |
| **Binge eating** |  |
| **Binge drinking** |  |
| **No appetite** |  |
| **Raging appetite** |  |
| **Mucous in stools** |  |
| **Blood in stools, bright red** |  |
| **Blood in stools, dark** |  |
| **Diarrhoea** |  |
| **Constipation** |  |
| **Other** |  |
|  |  |
| **RECTUM** |  |
| **Rectal itching** |  |
| **Haemorrhoids** |  |
| **Anal fissure** |  |
|  |  |
| **SKIN** |  |
| **Acne** |  |
| **Hives/rashes/itchy** |  |
| **Dry flaky skin** |  |
| **Hot flushes during the day** |  |
| **Excessive sweating at night** |  |
| **No sweating at all** |  |
| **Scalp issues** |  |
| **Other** |  |
|  |  |
| **WEIGHT** |  |
| **Underweight** |  |
| **Excess weight** |  |
| **Water retention (oedema)** |  |
|  |  |
| **URINATION** |  |
| **Frequent painful urination** |  |
| **Urgent urination** |  |
| **Genital itching** |  |
| **Discharge** |  |
| **Nocturnal visits to the toilet** |  |
| **Bedwetting (Enuresis)** |  |
| **Other** |  |
|  |  |
| **HEART** |  |
| **Pain around the heart area** |  |
| **Irregular heartbeat** |  |
| **Skipped heartbeat** |  |
| **Palpitations** |  |
| **Pounding heartbeat** |  |
| **Low blood pressure** |  |
| **High blood pressure** |  |
| **Other** |  |
|  |  |
| **FEMALE** |  |
| **Loss of libido** |  |
| **Other** |  |
|  |  |
| **MALE** |  |
| **Loss of libido** |  |
| **Erectile issues** |  |
| **Other** |  |
|  |  |
| **MUSCLES & BONES** |  |
| **Joint aches** |  |
| **Muscle aches** |  |
| **Stiffness or limitation of movement** |  |
| **Feeling of weakness in the muscles** |  |
| **Recurrent back/neck/shoulder aches** |  |
| **Numbness in extremities** |  |
| **Burning in extremities** |  |
| **Tingling in extremities** |  |
| **Cold hands** |  |
| **Cold feet** |  |
| **Other** |  |
| **TOTAL (possible 139)** |  |

**FEMALE (Extra)**

**The Contraceptive Pill:**

**Length of time on the Contraceptive Pill \_\_\_\_\_\_\_**

**Type of contraceptive Pill \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Periods:**

**Length of cycle (28 days is an average) \_\_\_\_\_**

**How long do you bleed for generally \_\_\_\_\_\_\_\_\_\_\_**

**Painful \_\_\_**

**Heavy \_\_\_**

**Light \_\_\_**

**With cramps \_\_\_**

**PMT \_\_\_**

**How many pregnancies have you had \_\_\_\_**

**How many miscarriages have you had \_\_\_\_**

**How many terminations have you had \_\_\_\_**

**Have you ever had infertility issues \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you ever needed assisted fertility \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Are you:**

**Peri-menopausal (**it is characterized by irregular cycles of ovulation and menstruation and ends 12 months after the last menstrual period) **\_\_\_**

**Menopausal (**a point in time 12 months after a woman's last period) \_\_\_\_

**Post menopausal (**referring to the cessation of menstruation for ≥ 1 year)\_\_\_

**Bowel motions:**

**LIST OF SURGERY/HOSPITAL VISITS SINCE BIRTH with dates.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Colour and consistency of stools in general:

\_\_Pale grey

\_\_Light brown

\_\_Mid brown

\_\_Dark brown

\_\_Green

\_\_Yellow

\_\_Diarrhoea

\_\_Constipation

No of stools passed per day: X \_\_\_\_\_\_\_\_\_\_\_\_

**Immunity:**

True Allergies/serious reactions:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Intolerances:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Self-healing** (recovery time if you cut yourself!)

\_\_ Good

\_\_ Poor

**5. ANTI-BIOTIC & STEROID USE**

How many prolonged courses of **steroids or antibiotics** have you taken in the past year?

None \_\_\_ 1x \_\_\_2x\_\_\_3x\_\_\_ more\_\_\_

In the past 5 years : 3x\_\_\_4x\_\_\_5x\_\_\_6x\_\_\_7x\_\_\_8x\_\_\_more \_\_\_

As a teenager were you given long term antibiotics for acne, or other bacterial infections Yes \_\_ No \_\_

Did you suffer from attention deficit disorder (ADD) as a child? Yes \_\_ No \_\_

**6. BITES**

Have you ever been bitten by an animal or insect? What date approx., where on the body and did you develop a bull’s eye rash like in the illustration?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. CURRENT AND/ PAST STRESS/TRAUMA

Please if you are able, list any past traumas in order of event history:

|  |  |
| --- | --- |
| Date | Brief description |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Have you ever been diagnosed with **PTSD** (Post Traumatic Stress Disorder) \_\_\_\_\_\_\_\_ If so when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What factors most contribute to your current stress? Please circle.**

Health Work Money Family Marriage Other

##### 8.List the medications you are currently taking, both over the counter and prescribed :

|  |  |  |
| --- | --- | --- |
| Medication | Dose/day | How long have you been on them ? |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |
| 8 |  |  |

##### 9.List all the supplements / homeopathics or herbal medicines you are currently taking :

|  |  |  |
| --- | --- | --- |
| Supplements | Dose/day | How long have you been on them ? |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |
| 5 |  |  |
| 6 |  |  |
| 7 |  |  |

**10List any adverse reactions you have had to any medication or supplements :**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

##### 11.List any other treatments / therapies you are partaking of at the present time : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### 12.Briefly list your previous treatments and detoxification history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. MOTIVATION**

Please rate your level of motivation to affect change in your health (10 = motivated)

1 2 3 4 5 6 7 8 9 10

Please rate your current level of Health (10 = excellent)

1 2 3 4 5 6 7 8 9 10

**Thank – you for taking the time to fill out this overview form.**

**This information will greatly assist me in helping you achieve your healthcare goals.**

**Please use this area and overleaf for writing anything else you feel is relevant in terms of your current or past health and then post it off to the clinic address below.**

PLEASE NOTE: The information you provide on this medical assessment is confidential and will not be passed on to any third party without the consent of you the patient. It will not be stored on any device that would allow access to it via the internet. This is in accordance with current Data Protection legislation.

Clinic contact details: please ask for full address once you are booked in for a consult.

Clinic of Natural Medicine

Claughton On Brock Nr Preston, Lancs

Tel 01995 605446

[www.clinicofnaturalmedicine.uk](http://www.clinicofnaturalmedicine.uk)

[info@clinicofnaturalmedicine.uk](mailto:info@clinicofnaturalmedicine.uk)