Consultation Sheet (Confidential) Date

Name………………………………………………………… D.O.B………………
Address ………………………………………………… Age ……………………..
……………………………………………………………. Tel.No……………………..
Email………………………………………… Mobile……………………..
Marital Status ………………………………………. Height …………………….
Children ………………………………………………….. Weight ……………………
Occupation………………………………………………………. Religion…………………..
Hobbies ……………………………………………………………………………………………..
Physical Activity …………………………………………………………………………..
……………………………………………………………………………………………………
Name and Address of Dr. ………………………………………………………………
……………………………………………………………. Tel: ………………………..
When last visited …………………………………………………………………………
Drugs prescribed (being taken)………………………………………………………..
……………………………………………………………………………………………………..
……………………………………………………………………………………………………
Diagnosis from Doctor/date ……………………………………………
……………………………………………………………………………
……………………………………………………………………………

Data Protection Act …………………………………………………………
……………………………………………………………………………
Are you a carer? ………………………………………………………………
Are you happy to be sent promotions and offers ……………………
Are you happy for your comments and/images to be used in future publicity material and on the WiserHealth website if only your first name and area are used? E.g. Janet, Plympton………………………

Presenting Problems/symptoms

……………………………………………………………………………………………………
……………………………………………………………………………………………………..
How long have you had this? ……………………………………………………………..
Does anything make it better/worse? ………………………………………………..
……………………………………………………………………………………………………..
How does it make you feel? ……………………………………………………………

Medical History

Previous medical conditions including serious or chronic illness………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
Operations (dates) ……………………………………………………………
……………………………………………………………………………………………………
Accidents (dates) ……………………………………………………………………...
……………………………………………………………………………………………………
Freguent coughs or colds ………………………………………………………………...
Recent trauma (within the last 2 years) ……………………………………………
……………………………………………………………………………………………………

Agreement Signature

I agree this is a true representation of my health status.
Signature/Date.........…………………………………………………………………...

Alimentary

Loss of Appetite ……………………… Dry Mouth ………………………………….
Indigestion …………………………….. Constipation ……………………………
Diarrhoea ……………………………… Flatulence ………………………………….
Skin Irritations ……………………… Stomach pains ……………………….
How regular ……………………………………………………………………………

Nervous System

Headaches (type) ……………………………………………………………………..
Insomnia (sleep patterns) …………………………………………………………...
Excessive Sweating …………… Drowsiness ………………………………..
Fits/Twitching/Epilepsy …………………………………………………………….

Skeletal System

Spine ………………………………………………………………………………………
Osteoporosis ………………………… Arthritis …………………………………….
Rheumatism ………………………… Teeth ………………………………………..

Renal System

Kidney Problems …………………. Fluid Retention ………………………….
Cystitis ………………………………… Stress Incontinence ………………….

Respiratory System

Breathlessness ……………………… Coughing
Asthma (How Long) ……………………………………………………………….
Any known allergies ………………………………………………………………….

Circulatory

Palpitations…………………………….. Heart Problems ……………………….
Varicose veins ……………………….. Blood Pressure ………………………….
Very cold hands/feet …………….. Cramps ……………………………………..
Haemorrhoids (For how long) ……………………………………………………….

Glandular System

Prostate ………………………………….. Thyroid ……………………………………..
Diabetes ……………………………………………………………………………………….

Periods

Regular/irregular …………………….. Amenorrhoea(none)…………………..
Dysmenorrhoea(heavy) ………….. Bloating ………………………………………..
PMT ………………………………………….. Menopausal ……………………………….
Pregnancies ……………………………………………………………………………….

Liver/gall bladder

Eyes ………………………………………….. Ears …………………………………………
Sleep (no. of hours, quality, dreams) …………………………………………………
…………………………………………………………………………………………………
…………………………………………………………………………………………………

Diet

Typical days food

………………………………………………………………………………………………………
………………………………………………………………………………………………………
………………………………………………………………………………………………………

Wholefoods……………………………….. Grains …………………………………….
Fruit ……………………………………….. Sugar ……………………………………..
Veg (cooked) ………………………….. Raw …………………………………………
Protein ……………………………………. Alcohol ……………………………………
Salt …………………………………………. Tea …………………………………………
Coffee………………………………………. Other drinks …………………………..
Water ……………………………………

Smoker (current, previous or passive, for how long ………………………..
Do you relax easily? ……………………………………………………………………
Any previous complementary therapies?
………………………………………………………………………………………………………
How do you feel today?
What are you hoping to achieve from your session today? ……………..
……………………………………………………………………………………………………..
Is there anything about your health that you would like to change?..
....
....
Would you like me to include that in your treatment plan?.............
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Additional Information

Presenting Problems/symptoms continued
………………………………………………………………………………………………………
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Treatment Plan

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Feedback from First Treatment Date…………………………………..

How did you feel after your first treatment? (side effects?) …………….
……………………………………………………………………………………………………
……………………………………………………………………………………………………
……………………………………………………………………………………………………
Do you feel you have seen an improvement in your symptoms? ……
……………………………………………………………………………………………………
……………………………………………………………………………………………………
…………………………………………………………………………………………………..
Do you feel confident about the treatment plan suggested? …………….
……………………………………………………………………………………………………
……………………………………………………………………………………………………
…………………………………………………………………………………………………..
What do you feel you would like to get out of today's treatment?....
……………………………………………………………………………………………………
Is there anything else you'd like to add? ……………………………………………..