Pre Consult health screen form

First Name: ______________________ Address 1: ______________________

Last Name: ______________________ Address 2: ______________________

Dob/Age: ______________________ Work Phone: ______________________

Sex: ☐ F ☐ M Home Phone: ______________________

Occupation: ______________________ Mobile: ______________________

Ethnicity: ______________________ E-Mail: ______________________

Blood Group: ______________________

How did you hear about our practice?
Please name the person that referred you so we can thank them. ______________________

What are your main concerns in regards to your health? ______________________

Question		
Has anyone in your family suffered from heart disease prior to the age of 60?	☐ Yes	☐ No
Are you on prescription medication?	☐ Yes	☐ No
Do you take any supplements or herbal remedies?	☐ Yes	☐ No
Have you been hospitalized OR had anaesthesia recently?	☐ Yes	☐ No
Have you given birth in the last 2 years?	☐ Yes	☐ No
Are you pregnant?	☐ Yes	☐ No
Are you a blood donor?	☐ Yes	☐ No
Do you have an annual flu vaccination?	☐ Yes	☐ No
Do you use any form of hormonal contraception?	☐ Yes	☐ No
Do you have any allergies or intolerances?	☐ Yes	☐ No

If YES to any of the above, please provide details here: ______________________

Do you have or have you had any of the following:

Heart Condition	☐	Thyroid Disorders	☐	Osteoporosis	☐	Hernia	☐
Stroke	☐	Diabetes	☐	Gout	☐	Allergies	☐
Rheumatic Fever	☐	Hypertension	☐	Headaches/Migraines	☐	Asthma/Eczema	☐
Dizziness or Fainting	☐	Hypoglycemia	☐	Depression/Anxiety	☐	Glandular Fever	☐
Anemia	☐	Liver / Kidney Condition	☐	Irritable Bowel Syndrome	☐	Perimenopause	☐
Epilepsy	☐	Hepatitis	☐	Inflammatory Bowel Disease	☐	Menopause	☐
Cancer	☐	Arthritis	☐	Stomach Ulcer	☐		

If YES to any of the above, please provide details here: ______________________

Do you smoke?	☐ Yes ☐ No	If yes, how many per day? ____________
Do you drink alcohol?	☐ Yes ☐ No	If yes, how much per day/week? ____________
Are you sensitive to strong smells perfumes paints/detergents/traffic or cigarette smoke?	☐ Yes ☐ No	If yes, what effect does this have on you? ____________

Please fill out the following questionnaire.

Do not 'over think' your answers. Your initial responses are sufficient.
Select the number which best describes the frequency of your symptoms.
If you do not know the answer to a question, leave it blank.

0 = never or rarely 1 = twice a week or less 2 = three to six times a week 3 = daily or several times a day

Stress:

Question	Answer
Do you often feel anxious or stressed?	☐0 ☐1 ☐2 ☐3
Do you feel anti social?	☐0 ☐1 ☐2 ☐3
Do you feel like you are always rushing around?	☐0 ☐1 ☐2 ☐3
Do you struggle with time management?	☐0 ☐1 ☐2 ☐3
Do you need stimulants to get you through the day?	☐0 ☐1 ☐2 ☐3
Do you experience flat moods?	☐0 ☐1 ☐2 ☐3
Do you have constant negative thoughts?	☐0 ☐1 ☐2 ☐3
Do you frequently lash out at others?	☐0 ☐1 ☐2 ☐3
Do you openly vent your frustrations socially?	☐0 ☐1 ☐2 ☐3
Do you over react easily?	☐0 ☐1 ☐2 ☐3
Do you get foggy headed and have decreased memory?	☐0 ☐1 ☐2 ☐3
Do you frequently lash out at others?	☐0 ☐1 ☐2 ☐3
Do you feel panicky at times?	☐0 ☐1 ☐2 ☐3
Do your moods fluctuate?	☐0 ☐1 ☐2 ☐3

Digestion:

Question	Answer
Do you get bloating and/or wind?	☐0 ☐1 ☐2 ☐3
How often do you have bowel motions?	☐0 ☐1 ☐2 ☐3
Do you get heartburn/reflux/indigestion?	☐0 ☐1 ☐2 ☐3
Do you have painful, difficultly straining during bowel movements?	☐0 ☐1 ☐2 ☐3
Do you experience gut pain?	☐0 ☐1 ☐2 ☐3
Do you have extremely narrow stools?	☐0 ☐1 ☐2 ☐3
Do you experience alternating diarrhoea / constipation?	☐0 ☐1 ☐2 ☐3
Have you seen mucus and/or pus in stool?	☐0 ☐1 ☐2 ☐3
Do you have loose stools or diarrhoea?	☐0 ☐1 ☐2 ☐3
Do you belch/burp after meals?	☐0 ☐1 ☐2 ☐3
Are your stools hard, dry or pellet like?	☐0 ☐1 ☐2 ☐3
Do you feel your energy drops quickly throughout the day?	☐0 ☐1 ☐2 ☐3
Do you crave carbohydrate/sweet foods?	☐0 ☐1 ☐2 ☐3
Do your digestive problems subside with rest and relaxation?	☐0 ☐1 ☐2 ☐3
Do you feel your bowels do not empty completely?	☐0 ☐1 ☐2 ☐3
Have you seen bright red blood following bowel movements?	☐0 ☐1 ☐2 ☐3

Detoxification:

Question	Answer
Do you feel fatigued or sluggish?	☐0 ☐1 ☐2 ☐3
Do you have dark circles or puffy eyes?	☐0 ☐1 ☐2 ☐3
Do you have mental sluggishness/poor memory/poor concentration?	☐0 ☐1 ☐2 ☐3
Do you struggle to lose weight?	☐0 ☐1 ☐2 ☐3
Do you have headaches? If so how often?	☐0 ☐1 ☐2 ☐3
Are you unable to lose cellulite?	☐0 ☐1 ☐2 ☐3

Thyroid:

Question	Answer
Do you struggle to lose weight?	☐0 ☐1 ☐2 ☐3
Are your eyebrows thinning?	☐0 ☐1 ☐2 ☐3
Do you have dry skin?	☐0 ☐1 ☐2 ☐3
Do you feel tired all the time?	☐0 ☐1 ☐2 ☐3
Do you have swelling of the neck	☐ Yes ☐ No
Feel cold – hands, feet, all over	☐0 ☐1 ☐2 ☐3
Do you have thinning or course hair?	☐0 ☐1 ☐2 ☐3
Do you feel the cold easily?	☐0 ☐1 ☐2 ☐3
Do you have sluggish bowels?	☐0 ☐1 ☐2 ☐3
Slow mental processes, forgetfulness	☐0 ☐1 ☐2 ☐3

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Cardiovascular:

Have you ever had high BP? □ Yes □ No

Do you easily get short of breath? □0 □1 □2 □3

Have you ever smoked? □ Yes □ No

Do you have diabetes? □ Yes □ No

Do you suffer heart palpitations (slow, rapid or irregular heart beat) or arrhythmias? □ Yes □ No

Any history of heart murmur? □ Yes □ No

Do you suffer from swelling of feet, ankles & legs? □ Yes □ No

Do you every get dizzy? □0 □1 □2 □3

Have you ever had high cholesterol? □ Yes □ No

Do you have a family history of heart disease? □ Yes □ No

Do you do less than 2 hours of exercise per week? □ Yes □ No

Are you in a stressful environment? □ Yes □ No

Women's health:

Do you get heavy periods? □ Yes □ No

Do you get clots? □ Yes □ No

Do they last longer than 5 days? □ Yes □ No

Are they irregular? □ Yes □ No

Do you suffer from hot flushes or increased feelings of heat? □0 □1 □2 □3

Do you have PCOS or endometriosis? □ Yes □ No

Do you have regular breast examinations and smear tests? □ Yes □ No

Do you get PMS or breast tenderness? □ Yes □ No

Do you have pain or bleeding with intercourse? □ Yes □ No

Are you experiencing increased irritability, anxiety or depression? □ Yes □ No

Men's health:

Do you experience poor sex drive? □ Yes □ No

Do you have regular prostate checks? □ Yes □ No

Do they last longer than 5 days? □ Yes □ No

Do you have problems urinating? □0 □1 □2 □3

Does ejaculation cause pain? □0 □1 □2 □3

Immunity:

Do you frequently suffer from a cold or flu? □0 □1 □2 □3

Do you have high sensitivity to allergens? □ Yes □ No

Do you have any autoimmune conditions? □ Yes □ No

Do you have a post nasal drip? □0 □1 □2 □3

Do you experience muscle and/or joint pain or stiffness? □0 □1 □2 □3

Do your wounds heal slowly? □ Yes □ No

When was the last time you took antibiotics? ____________ dd/mm/yyyy

Do you experience recurrent bouts of illness? □0 □1 □2 □3

Have you ever used antibiotics? □0 □1 □2 □3

Do you have susceptibility to infections? □0 □1 □2 □3

Do you have increased congestion in sinuses? □0 □1 □2 □3

Do you get cold sores? □ Yes □ No

Do you have bumpy skin on the back of your arms? □ Yes □ No

Insomnia:

Do you struggle to get to sleep? □ Yes □ No

Do you take sedatives to aid in sleep? □0 □1 □2 □3

Do you feel refreshed when waking? □ Yes □ No

Do you wake up during the night? □0 □1 □2 □3

Are you restless when trying to sleep? □0 □1 □2 □3

Skin:
Do you have any of the following

Rashes □ Yes □ No

Psoriasis □ Yes □ No

Acne □ Yes □ No

Eczema □ Yes □ No

Dry flaky skin or scalp □ Yes □ No

Skin tags □ Yes □ No

Are there any other factors you think we should know about? ____________________

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I recognise that by providing my practitioner with complete details of my health history, I am enabling them to regard all aspects of my previous and current health status in my treatment. By not disclosing vital information this may have an impact on the success of my treatment outcomes. I have answered all of the questions to best of my ability and I understand the statement above. All of my case details are confidential and will be treated as such by my practitioner.

Client: ____________________ **Date:** ____________ dd/mm/yyyy

Practitioner: ____________________ **Date:** ____________ dd/mm/yyyy

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