Homeopathic Health Centre

Strictly Patient Confidentiality

Consultation Form

Please complete all fields as they are an important part of your diagnosis and also explain where recommended your symptoms and what medications you are taking.

Patient Reference No:	
Patient:	**New** ☐ **Existing** ☐
Date Registered:	/ /

Patient Details

First Name:	**Middle Name:**	**Surname:**	**Date Of Birth:**
Address: **Post Code:**			**Contact Tel:** **Mobile Number:**
Email:		**Gender:** (Please Tick Appropriate box) **Male:** ☐ **Female:** ☐	

About Your Health

Height:	**Weight:**	**Do you exercise on a regular basis?** (Please Tick Appropriate box) **Yes** ☐ **No** ☐ **Sometimes** ☐	**Do you smoke?** **Yes** ☐ **No** ☐ **Do you take alcohol?** **Yes** ☐ **No** ☐

Any On-going Treatment? **Yes** ☐ **No** ☐ ****If Yes please describe****

Your Fitness:
Do you consider yourself to be:
Very Fit ☐ **Normal** ☐ **Over Weight** ☐ **Under Weight** ☐

Do You Suffer From The Following? (Tick Only That Apply)

Digestive System Disorders:

Diarrhoea Yes ☐ No ☐	**Indegestion** Yes ☐ No ☐	**Constipation** Yes ☐ No ☐	**Irritable Bowel Syndrome** Yes ☐ No ☐
Eating Disorder Yes ☐ No ☐	**Crohn's Disease** Yes ☐ No ☐	**Bloated Stomach** Yes ☐ No ☐	**Piles of Haemorrhoids** Yes ☐ No ☐

Problems Concerning Women (Tick Only That Apply)

Fibroid Yes ☐ No ☐	**Hot Flush** Yes ☐ No ☐	**Night Sweat** Yes ☐ No ☐	**Forgetfullness** Yes ☐ No ☐
Loss of Libido Yes ☐ No ☐	**Painful Period** Yes ☐ No ☐	**Endometeriosis** Yes ☐ No ☐	**Pins and Needles** Yes ☐ No ☐
Irregular Periods Yes ☐ No ☐	**Vaginal Dryness** Yes ☐ No ☐	**Tearful/Agitated** Yes ☐ No ☐	**Menstrual Bleeding** Yes ☐ No ☐
Thrush/Discharge Yes ☐ No ☐	**Pregnancy/Fertility** Yes ☐ No ☐	**Lack of Concentration** Yes ☐ No ☐	**Premenstrual Tension** Yes ☐ No ☐
Polycystic Ovary Syndrome Yes ☐ No ☐	**Kidney Disorders** Yes ☐ No ☐	**Back Pains** Yes ☐ No ☐	

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Problems Concerning Men (Tick Only That Apply)			
Impotence Yes ☐ No ☐	Low Sperm Yes ☐ No ☐	Enlarged Prostate Yes ☐ No ☐	Erectile Weakness Yes ☐ No ☐
Premature Ejaculation Yes ☐ No ☐	Kidney Disorders Yes ☐ No ☐	Urinating Blood Yes ☐ No ☐	

Muscular/Pain Related Problems (Tick Only That Apply)			
RSI Yes ☐ No ☐	Scatica Yes ☐ No ☐	Scoloisis Yes ☐ No ☐	Knee Issues Yes ☐ No ☐
Stiff Knee Yes ☐ No ☐	Neuralgia Yes ☐ No ☐	Back Pain Yes ☐ No ☐	Tendonitis Yes ☐ No ☐
Tennis Elbow Yes ☐ No ☐	Golfer's Elbow Yes ☐ No ☐	Trapped Nerve Yes ☐ No ☐	Frozen Shoulder Yes ☐ No ☐

Mental/Neurological Issues (Tick Only That Apply)			
Stress Yes ☐ No ☐	Headache Yes ☐ No ☐	Anxiety Yes ☐ No ☐	Migraine Yes ☐ No ☐
Phobias (If Yes Please Describe) Yes ☐ No ☐		Tremors Yes ☐ No ☐	Stroke Yes ☐ No ☐ TIA (Minor Stroke) Yes ☐ No ☐
Insomnia Yes ☐ No ☐	Depression Yes ☐ No ☐	Facial Palsy Yes ☐ No ☐	Panic Attacks Yes ☐ No ☐
Cerebral Palsy Yes ☐ No ☐	Shingles/ Herpes Yes ☐ No ☐	Multiple Sclerosis Yes ☐ No ☐	Fealing run Down Yes ☐ No ☐
Loss of Smell Yes ☐ No ☐	Loss of Taste Yes ☐ No ☐	Low Energy Yes ☐ No ☐	Tiredness Yes ☐ No ☐

Skin/Hair Disorders (Tick Only That Apply)			
Acne Yes ☐ No ☐	Herpes Yes ☐ No ☐	Eczema Dry Yes ☐ No ☐ Wet Yes ☐ No ☐	Vitiligo Yes ☐ No ☐
Psoriasis Yes ☐ No ☐	Hair Loss Yes ☐ No ☐	Dermatitis Yes ☐ No ☐	
Others Yes ☐ No ☐ (Please explain condition)			

Respiratory Problems (Tick Only That Apply) - Do you suffer from:-			
Asthma Yes ☐ No ☐	Sinusitis Yes ☐ No ☐	Hay Fever Yes ☐ No ☐	Bronchitis Yes ☐ No ☐
Emphysema Yes ☐ No ☐	Chronic Cough Yes ☐ No ☐	Angina Attack Yes ☐ No ☐	Heart Attack Yes ☐ No ☐
When did you last Suffer an Angina/Heart attack? Did you undergo angioplasty surgery or heart bypass transplant? (please confirm) Are you undertaking medication? If yes which ones?			

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Other Problems (Tick Only That Apply)			
Obesity Yes ☐ No ☐	**Diabetes** Type 1 Yes ☐ No ☐ Type 2 Yes ☐ No ☐	**Cholesterol level** High ☐ Low ☐ Cholesterol level reading: ----------	**Hepatitis** Hep A Yes ☐ No ☐ Hep B Yes ☐ No ☐ Hep C Yes ☐ No ☐
Tinnitus Yes ☐ No ☐	**Palpitations** Yes ☐ No ☐	**Water Retention** Yes ☐ No ☐	**Thyroid disorder** Overactive Yes ☐ No ☐ Underactive Yes ☐ No ☐
Bed Wetting Yes ☐ No ☐	**Incontnency** Yes ☐ No ☐	**Blood in Urine** Yes ☐ No ☐	**Urination** Frequent Yes ☐ No ☐ Overactive Yes ☐ No ☐ Underactive Yes ☐ No ☐
Kidney Stones Yes ☐ No ☐	**Blood Pressure** High Yes ☐ No ☐ Low Yes ☐ No ☐	**Blood sugar level reading** ----------	**Blood pressure reading** ----------

What other illnesses do you suffer from? (Please Describe)

Post Completed Consultation Form To:

Homeopathic Health Centre,
Consultation & Registrations Department,
78-79 Pinfold Street,
Darlaston,
Wednesbury,
West Midlands,
WS10 8TB
United Kingdom

Day Surgery Tel:
0121 526 6449

Evening Surgery Tel:
0121 328 6698

24hr Contact Tel : 07956662877