

Consultation Record

Date: ____ / ____ / ____

Mothers name:

Fathers name:

Surname: _____

First name: _____

DOB: ____/____/____

Age: _____

Address: _____

Postcode: _____

Phone Home: _____ Parent Business: _____ Mobile: _____

Occupation father: _____ e-Mail _____

Occupation mother: _____ e-Mail: _____

Number of your brothers & sisters: _____ You are: 1st 2nd 3rd other: (circle)

Brothers & sisters: names and age now:

Outline of growing up background including key events:

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Medical History:

Major Diseases/Illnesses (include year)

Operations

Accidents

Sleep patterns or difficulties

Drugs taken:

Exercise Type/Frequency:

Energy level (1-10 - 10 is max): _____

Sleep

Supplements/Vitamins:

Fillings in teeth Yes /No:

Diet: Food Preferences/Cravings

Sensitivities/Allergies

Hobbies & Interests

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Please answer the following questions. There are no "right" or "wrong" answers.
If you do not understand a question, or do not have an answer, please leave a space.

1. How much stress do you feel you are experiencing in your life?

(Circle the one that best indicates how you feel)

(No stress=)0 1 2 3 4 5 6 7 8 9 10(= Maximum).

2. Why have you come - what issues have you come to resolve?

3. How does this issue express itself in your life? (Tick and elaborate as appropriate)

- Physical symptoms _____
- Learning difficulties _____
- Interpersonal conflict _____
- Interpersonal difficulties _____
- Low energy levels _____
- Phobias _____
- Other _____

4. How much stress do you feel you are experiencing about the presenting issue?

(Circle the one that best indicates how you feel usually)

(No stress=0) 1 2 3 4 5 6 7 8 9 (10= Maximum).

5. What outcome do you hope to achieve from the consultations?

Please comment

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6. How will you know that you have achieved this outcome?

Please comment

7. How much pain do you feel you are experiencing in your life ?

(Circle the one that best indicates how you feel usually)

(No pain=) 0 1 2 3 4 5 6 7 8 9 10 (= Maximum).

7a. Give a measure from 1 to 10 that best describes the amount of each type of pain that you feel

Physical Pain		Emotional Pain		Mental Pain	
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8. Are you undertaking any other treatment in addition to this consultation for this issue ?

YES NO. If yes,

8 (a). What techniques do these other treatments involve: (tick as many as required)

- | | | |
|---|--------------------------------------|--|
| <input type="checkbox"/> Chiropractic. | <input type="checkbox"/> Reflexology | <input type="checkbox"/> Kinesiology |
| <input type="checkbox"/> Shiatsu | <input type="checkbox"/> Reiki | <input type="checkbox"/> Naturopathy. |
| <input type="checkbox"/> Herbs. | <input type="checkbox"/> Massage | <input type="checkbox"/> Treatment by a Medical Doctor |
| <input type="checkbox"/> Physiotherapy | <input type="checkbox"/> Psychology | <input type="checkbox"/> Psychiatry |
| <input type="checkbox"/> Other please specify | | |

9. Any other comments:

Referred by: _____