Consultation Record

Date: _____ / _____ / _____ **Health Insurance:**

Surname: _____ **First name:** _____

DOB: ____/_____/ _____ Age: _____

Address: _____

_____ Postcode: _____

Phone Home: _____ Business: _____ Mobile: _____

Occupation: _____ e-Mail _____

Marital status: _____ Partners name _____

Your children: (name, age)

_____

_____

_____

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:

_____

_____

_____

_____

_____

_____

_____

Consultation Record

Growing up background including key events, (continued)

Consultation Record

Medical History: Major Diseases/Illnesses (include year)

Operations

Accidents

Drugs taken: (current & past, include smoking)

Sleep patterns or difficulties

Exercise Type/Frequency:

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

Supplements/Vitamins:

Fillings in teeth Yes /No:

Food Preferences/Cravings

Sensitivities/Allergies

Hobbies & Interests

Consultation Record

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. What issue/s have you come to resolve?

_____

_____

_____

_____

_____

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_____

_____

_____

_____

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. What would you like to be different in your life?
Please comment

_____

_____

_____

_____

_____

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_____

_____

5. How will you know that you have achieved this?

Please comment

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_____

. 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	

8. Are you undertaking any other treatments

YES NO. If yes,

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

- ❑ Chiropractic. ❑ Reflexology ❑ Kinesiology
- ❑ Shiatsu ❑ Reiki ❑ Naturopathy.
- ❑ Herbs. ❑ Massage ❑ Treatment by a Medical Doctor
- ❑ Physiotherapy ❑ Psychology ❑ Psychiatry
- ❑ Other please specify _____

9. Any other comments:

_____

_____

_____

Referred by: _____