New Patient Questionnaire

Please complete this form carefully and thoroughly.
This information is of genuine value to your treatment and will be kept confidential.

Name ………………………………………………………………………………………… **Date** ……………………….....

Address ……......

…… **Post Code** …………………...

Telephone No(s) ………

Email address: ……..

Date of Birth ……………………………………………………………………………… **Age**……………………………….

Occupation ………………………………………………………………………… **Are you a smoker?** ....

Referred by: Family / Friend / G.P. / Advert / Other – Please specify ....

General Practitioner ……………………………………………………………………………………………………….

Address ………......

………......

Telephone No. ……………………………………………………………………………..

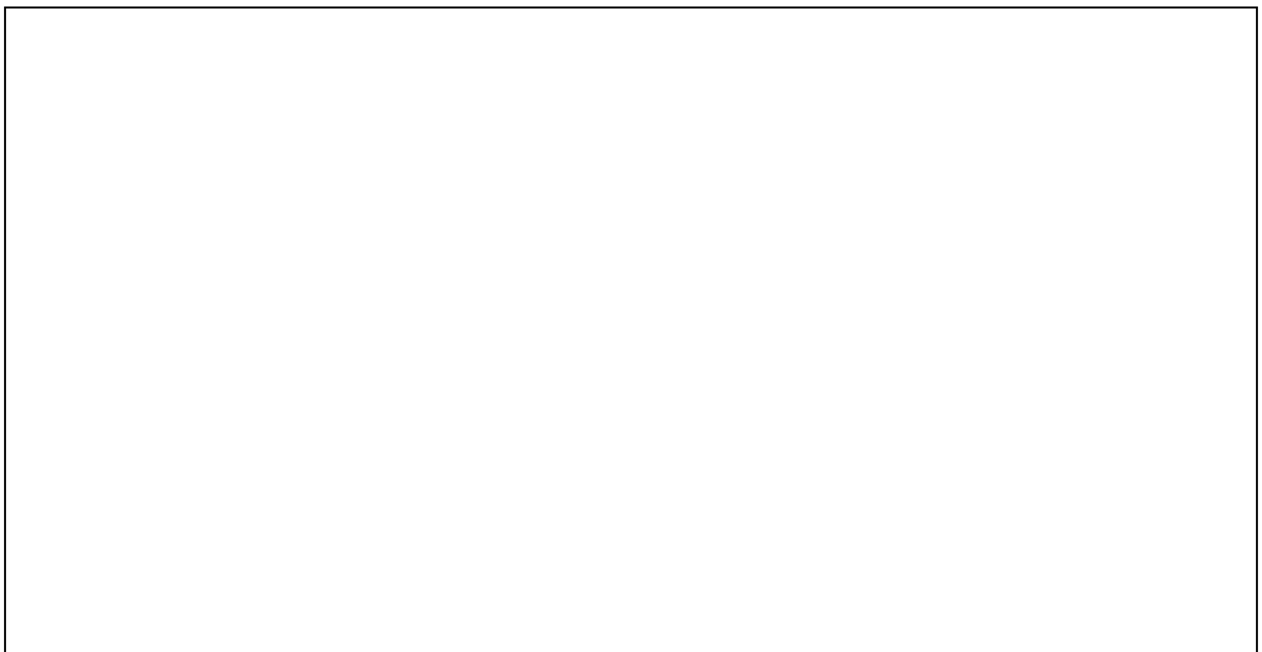
****

I CONFIRM THAT I REQUEST HOMEOPATHIC TREATMENT FROM LAURA SPITTALL LCPH, MARH.

Signed ………………………………………………………………….. **Date** ………………………………….

Describe the condition(s) about which you would like to consult me:

Any other information that you think might be useful.



PRESENT TREATMENT

List any current medication including vitamins, supplements, long term prescriptions, such as birth control pill, HRT, statins, tranquillisers, anti-depressants, anti-histamines etc. (Include date started).

Allergies: Please list all allergies, past and present.

List any other current treatment and complimentary therapies:

Your Medical History

Please list:

- Childhood illness/ all major diseases
- Shocks/traumas (deaths, grief, accidents)
- Hospitalisations with treatment (including births)
- Use of drugs: heavy or prolonged use both recreation and prescribed
- Cosmetic surgery
- Major dental work.
- Severe viral infections.
- Anything else you feel appropriate.

Please do not worry if these are not in chronological order.

AGE	CONDITION	TREATMENT

Vaccinations: List all vaccinations and any adverse reactions.

Family Medical History

Please list

- All diseases of blood relations, starting with the age and cause of death if applicable. E.g Asthma, arthritis, bowel disorders, cancer, diabetes, heart, kidney, liver, lung disorders including cause and age of death where applicable.

Please also include:-

- Alcoholism
- Behavioural problems – eg hyperactivity
- Drug addiction
- Downs Syndrome
- Epilepsy/neurological conditions/depression
- Any other problems you feel appropriate.

Your Mother's Side	**Your Father's Side**
Mother	**Father**
Grandmother	**Grandmother**
Grandfather	**Grandfather**
Aunts	**Aunts**
Uncles	**Uncles**
Your Brothers and Sisters	
Your Children	