



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 <input type="checkbox"/>	Existing <input type="checkbox"/>
Date Registered:		/ /	
Patient Details			
First Name:	Middle Name:	Surname:	Date Of Birth:
Address:			Contact Tel:
Post Code:			Mobile Number:
Email:		Gender: (Please Tick Appropriate box) Male: <input type="checkbox"/> Female: <input type="checkbox"/>	
About Your Health			
Height:	Weight:	Do you exercise on a regular basis? (Please Tick Appropriate box) Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes <input type="checkbox"/>	Do you smoke? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you take alcohol? Yes <input type="checkbox"/> No <input type="checkbox"/>
Any On-going Treatment? Yes <input type="checkbox"/> No <input type="checkbox"/> **If Yes please describe**			
Your Fitness: Do you consider yourself to be: Very Fit <input type="checkbox"/> Normal <input type="checkbox"/> Over Weight <input type="checkbox"/> Under Weight <input type="checkbox"/>			
Do You Suffer From The Following? (Tick Only That Apply)			
Digestive System Disorders:			
Diarrhoea Yes <input type="checkbox"/> No <input type="checkbox"/>	Indigestion Yes <input type="checkbox"/> No <input type="checkbox"/>	Constipation Yes <input type="checkbox"/> No <input type="checkbox"/>	Irritable Bowel Syndrome Yes <input type="checkbox"/> No <input type="checkbox"/>
Eating Disorder Yes <input type="checkbox"/> No <input type="checkbox"/>	Crohn's Disease Yes <input type="checkbox"/> No <input type="checkbox"/>	Bloated Stomach Yes <input type="checkbox"/> No <input type="checkbox"/>	Piles of Haemorrhoids Yes <input type="checkbox"/> No <input type="checkbox"/>
Problems Concerning Women (Tick Only That Apply)			
Fibroid Yes <input type="checkbox"/> No <input type="checkbox"/>	Hot Flush Yes <input type="checkbox"/> No <input type="checkbox"/>	Night Sweat Yes <input type="checkbox"/> No <input type="checkbox"/>	Forgetfulness Yes <input type="checkbox"/> No <input type="checkbox"/>
Loss of Libido Yes <input type="checkbox"/> No <input type="checkbox"/>	Painful Period Yes <input type="checkbox"/> No <input type="checkbox"/>	Endometriosis Yes <input type="checkbox"/> No <input type="checkbox"/>	Pins and Needles Yes <input type="checkbox"/> No <input type="checkbox"/>
Irregular Periods Yes <input type="checkbox"/> No <input type="checkbox"/>	Vaginal Dryness Yes <input type="checkbox"/> No <input type="checkbox"/>	Tearful/Agitated Yes <input type="checkbox"/> No <input type="checkbox"/>	Menstrual Bleeding Yes <input type="checkbox"/> No <input type="checkbox"/>
Thrush/Discharge Yes <input type="checkbox"/> No <input type="checkbox"/>	Pregnancy/Fertility Yes <input type="checkbox"/> No <input type="checkbox"/>	Lack of Concentration Yes <input type="checkbox"/> No <input type="checkbox"/>	Pre-menstrual Tension Yes <input type="checkbox"/> No <input type="checkbox"/>
Polycystic Ovary Syndrome Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disorders Yes <input type="checkbox"/> No <input type="checkbox"/>	Back Pains Yes <input type="checkbox"/> No <input type="checkbox"/>	



Problems Concerning Men (Tick Only That Apply)			
Impotence Yes <input type="checkbox"/> No <input type="checkbox"/>	Low Sperm Yes <input type="checkbox"/> No <input type="checkbox"/>	Enlarged Prostate Yes <input type="checkbox"/> No <input type="checkbox"/>	Erectile Weakness Yes <input type="checkbox"/> No <input type="checkbox"/>
Premature Ejaculation Yes <input type="checkbox"/> No <input type="checkbox"/>	Kidney Disorders Yes <input type="checkbox"/> No <input type="checkbox"/>	Urinating Blood Yes <input type="checkbox"/> No <input type="checkbox"/>	

Muscular/Pain Related Problems (Tick Only That Apply)			
RSI Yes <input type="checkbox"/> No <input type="checkbox"/>	Scatica Yes <input type="checkbox"/> No <input type="checkbox"/>	Scoliosis Yes <input type="checkbox"/> No <input type="checkbox"/>	Knee Issues Yes <input type="checkbox"/> No <input type="checkbox"/>
Stiff Knee Yes <input type="checkbox"/> No <input type="checkbox"/>	Neuralgia Yes <input type="checkbox"/> No <input type="checkbox"/>	Back Pain Yes <input type="checkbox"/> No <input type="checkbox"/>	Tendonitis Yes <input type="checkbox"/> No <input type="checkbox"/>
Tennis Elbow Yes <input type="checkbox"/> No <input type="checkbox"/>	Golfer's Elbow Yes <input type="checkbox"/> No <input type="checkbox"/>	Trapped Nerve Yes <input type="checkbox"/> No <input type="checkbox"/>	Frozen Shoulder Yes <input type="checkbox"/> No <input type="checkbox"/>

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

Skin/Hair Disorders (Tick Only That Apply)			
Acne Yes <input type="checkbox"/> No <input type="checkbox"/>	Herpes Yes <input type="checkbox"/> No <input type="checkbox"/>	Eczema Dry Yes <input type="checkbox"/> No <input type="checkbox"/> Wet Yes <input type="checkbox"/> No <input type="checkbox"/>	Vitiligo Yes <input type="checkbox"/> No <input type="checkbox"/>
Psoriasis Yes <input type="checkbox"/> No <input type="checkbox"/>	Hair Loss Yes <input type="checkbox"/> No <input type="checkbox"/>	Dermatitis Yes <input type="checkbox"/> No <input type="checkbox"/>	
Others Yes <input type="checkbox"/> No <input type="checkbox"/> (Please explain condition)			

Respiratory Problems (Tick Only That Apply) - Do you suffer from:-			
Asthma Yes <input type="checkbox"/> No <input type="checkbox"/>	Sinusitis Yes <input type="checkbox"/> No <input type="checkbox"/>	Hay Fever Yes <input type="checkbox"/> No <input type="checkbox"/>	Bronchitis Yes <input type="checkbox"/> No <input type="checkbox"/>
Emphysema Yes <input type="checkbox"/> No <input type="checkbox"/>	Chronic Cough Yes <input type="checkbox"/> No <input type="checkbox"/>	Angina Attack Yes <input type="checkbox"/> No <input type="checkbox"/>	Heart Attack Yes <input type="checkbox"/> No <input type="checkbox"/>
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?			



Other Problems (Tick Only That Apply)			
Obesity Yes <input type="checkbox"/> No <input type="checkbox"/>	Diabetes Type 1 Yes <input type="checkbox"/> No <input type="checkbox"/> Type 2 Yes <input type="checkbox"/> No <input type="checkbox"/>	Cholesterol level High <input type="checkbox"/> Low <input type="checkbox"/> Cholesterol level reading: -----	Hepatitis Hep A Yes <input type="checkbox"/> No <input type="checkbox"/> Hep B Yes <input type="checkbox"/> No <input type="checkbox"/> Hep C Yes <input type="checkbox"/> No <input type="checkbox"/>
Tinnitus Yes <input type="checkbox"/> No <input type="checkbox"/>	Palpitations Yes <input type="checkbox"/> No <input type="checkbox"/>	Water Retention Yes <input type="checkbox"/> No <input type="checkbox"/>	Thyroid disorder Overactive Yes <input type="checkbox"/> No <input type="checkbox"/> Underactive Yes <input type="checkbox"/> No <input type="checkbox"/>
Bed Wetting Yes <input type="checkbox"/> No <input type="checkbox"/>	Incontinency Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood in Urine Yes <input type="checkbox"/> No <input type="checkbox"/>	Urination Frequent Yes <input type="checkbox"/> No <input type="checkbox"/> Overactive Yes <input type="checkbox"/> No <input type="checkbox"/> Underactive Yes <input type="checkbox"/> No <input type="checkbox"/>
Kidney Stones Yes <input type="checkbox"/> No <input type="checkbox"/>	Blood Pressure High Yes <input type="checkbox"/> No <input type="checkbox"/> Low Yes <input type="checkbox"/> No <input type="checkbox"/>	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