Patient Appointment Notes

Name: ..... DOB: ..... Age: ..... Email: .....

Address: ..... Tel: ..... Mob: .....

GP name: ..... Surgery name/ address:..... Tel: .....

Medications: ***If you are taking any prescription medication(s) please complete the separate Prescription List form & bring a copy prescription to your first Well Body Clinic consultation.***

YES - Please tick if you are taking any prescription medication(s) & complete the form
NO - Please delete this section if you not taking any prescription medication

What are you seeking help/ support for?

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My Primary Objective is: .....

.....

Medical History : Patient Primary / Secondary Presentation:
Please provide a brief outline of what you are seeking help for, listing dates of first onset, any accident, injury, impact, trauma or related illness, health condition or emotional episode. Please use the extra sheet if necessary (at end of this form)

DATE AGE PRESENTATION TREATMENT & DATE

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Medical History: Please detail any childhood illnesses, infection, accident/ injury or trauma:
This is an important factor of early somatic patterning & your body's experience of its early health or illness:

DATE AGE PRESENTATION ANY TREATMENT

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Do you have any of the following health conditions: Please circle as appropriate

DIABETES	HEART / CARDIO VASCULAR including STROKE	IBS/ CHRONES/ DIVERTICULITIS
ASTHMA	BRONCHITIS/ PNEUMONIA/ PLEURISY	CANCER
ME	FIBROMYALGIA	PARKINSONS

Overview / Review:

Are you experiencing Pain? Yes/ No

Please score your pain:
at its best/ lowest level /10 *(0/10 being zero pain)* When? .....
at its worst / 10 (10/10 being full pain) When?

Location of pain site:
Where is the primary pain felt?

Do you have any secondary or additional pain?

Please provide some detail about this:

Quality of pain: Acute (1 day - 3 weeks) or Chronic (4 weeks & more)

Texture of pain: sharp/ stabbing/ burning/ throbbing/ cramping/ acute ache/ dull ache/ tingling / numbness

Does this pain refer? How & where?

Is it constant / intermittent/ only on waking/ only at night / only on resting/ only on exertion / better for rest/ better for movement?

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Muscular / Skeletal: Please quickly scan through this list & tick/ delete with some brief detail/ notes:

Mobility/ Range of movement
- Cramps .....
- Stiffness .....
- Sensation of Cold/heat .....

- Cranial / Head.....
- Cervical /Neck .....
- Thoracic / Upper Back .....
- Lumbar / Lower Back .....
- Limbs/ Digits / Fingers & Toes .....

Scars:
Do you have any physical scars at all on your on body? If so where? (please detail approx date/ & intervention/ accident/ episode. Please include any body piercing, laparoscopy, or surgical intervention:
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Do you have any emotional / psychological scars? YES/ NO
If so, please share briefly .....

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If you feel unable to at this time, please indicate this is something that is part of your history, but that you would rather not share or explore this at this time
YES - this may be a factor.....

- Cranial / Head:
- Headaches .....
  - Forehead .....
  - Temples .....
  - Back of head .....
  - Top of head .....

- Eyes - Dry/ Gritty/ Itchy/ Sore/ Floaters/ Blurred .....
- Ears .....
- Tinnitus - low resonance/ high resonance / constant/ intermittent
- Memory/ Concentration

- Respiratory: Breathless/ dry cough/ mucus cough/ barking cough/ phlegm - colour?.....
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Thorax / Heart/ Epigastric/ Hypogastric/

Palpitations
On exertion? or at rest? Daytime?Nighttime? .....

Arrythmia .....

Stomach problems? please detail including time of day/ night & known triggers .....

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Reflux / vomiting? please detail .....

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Digestion:

Abdomen .....

Bloating? Cramps? .....

Bowel - Constipation/ Diarrhoea/ Interchangeable/ Mucus / Blood/ Haemorrhoids/

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Do you eat dairy? YES / NO
please detail: .....

Do you eat wheat? YES / NO
please detail: .....

Are you vegan/ vegetarian/ carnivore - white meat/ carnivore - red meat / carnivore - mixed meat

Do you eat breakfast? YES / NO
What time? Please detail your intake .....

Do you eat lunch? YES / NO
What time? Please detail your intake .....

Do you eat dinner? YES / NO
How much water intake? .....

Tea/ coffee? .....
Herbal tea? .....

Alcohol? .....

Gynae:

Last Period: .....

Cycle/ Day: .....

Other / Lower Umbilicus

Any surgery/ intervention?

Sleep:
Do you sleep well? YES / NO
Please describe the quality of your sleep:
Do you have problems getting to
sleep? .....
Do you have a pattern of or tendency to wake? If so, when (detail hours):
Do you need to relieve your bladder in the night?
Do you feel rested on waking?
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Temperature:
Are you sensitive to cold or heat during the day?
Are you sensitive to cold or heat during the evening of night?

Is any part of your body noticeably cold or warm?
please circle/ delete as appropriate

Hands	Cold	Warm	Hot	Daytime	Evening	Night
Feet	Cold	Warm	Hot	Daytime	Evening	Night
Lower back	Cold	Warm	Hot	Daytime	Evening	Night
Chest	Cold	Warm	Hot	Daytime	Evening	Night
Shoulders	Cold	Warm	Hot	Daytime	Evening	Night
Buttocks	Cold	Warm	Hot	Daytime	Evening	Night
Thighs	Cold	Warm	Hot	Daytime	Evening	Night

Do you ever sweat?

On light exertion	On exercise/ full exertion	Daytime	Evening	Night

Respiratory & Immunity:
Do you ever have a low level sore throat on waking? YES / NO
Does this go once you are up & about?
Is it constant or intermittent during the day?

Do you have coughs/ colds? FREQUENT/ INFREQUENT
ACUTE/ CHRONIC

Do you have a pattern of any past / present upper respiratory inflammation? Please detail:
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I confirm that all information given is correct to the best of my knowledge.
SIGNED: PRINT: DATE:

Notes:

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