Name
Date of Birth
Address
E Mail
Telephone and Mobile
Status
Living situation
Children/Grand Children and ages
Occupation
Main complaint
Duration of complaint
Location in the body
Quality/ Intensity of pain
How often dose this complain affect you
Is there any thing that you can no do because of this complaint
Any accompanying symptoms
Treatments you have had

Sleep
How many Hours do you sleep a night? **Time you go to Sleep?** **Time you get up?** **How well do you sleep?** **Do you wake to go for a wee?** **Do you wake thirsty and drink water?** **Do you Wake up feeling Tired?** **Do you get hot at night?** **Do you sweat at night?** **Do you have nightmares?** **Do you have dream disturbed sleep?** **Do you take sleeping Pills?** **If so how often?** **If you have insomnia please can you describe the nature of it?**
Appetite and Digestion **Do you have any of the following:** **Bloating/ Flatulence/Pain/ discomfort** **Can you describe how this affect you ?**
Is there any food that you dislike, or any food that you really love?
Diet **On an average day what would you have for** **Breakfast?** **Lunch?** **Dinner?** **Snacks?**
Drinks: **What would you normally drink in a day (coffee, tea, water, herbal tea) please include amount of cups.**
Do you drink alcohol, what kind, how much and how often.

Bowles
How often do you have a bowel movement?
Dose it tend do be Loose of solid?
Do you ever have Blood Mucus or undigested food in your stools?
Do you have pain before during or after a bowel movement (please describe)?

Urine:
Is your urine normally dark or light or cloudy?
Do you have blood in your urine?
Dose it have a very strong smell?
Do you have a burning sensation?
Is your urination difficult in any way?
Is there any pain?
Cystitis or Enuresis?

Do you sweat in the day with out exertion?
Is this a hot sweat or a cold sweat?
Dose this affect you palms, forehead and chest?
Do you feel the cold easily?
Do you feel hot during the day?

Headaches
How often:
What time of day?
What part of the Head?
Is there a feeling of heat with it?
IS there sickness with it?
Is there light sensitivity?
Can you describe the quality of pain?

Do you ever get Dizziness or light headed or a spaced out feeling?
Please describe?

Eyes
Blurred vision?
Floaters in the vision?
Pain in the eyes?
Bloodshot eyes?
Tired eyes?
Twitching eye?
Dry eyes?
Itchy eyes?
Red eyes?

Numbness/ Cramps /Pins and Needles
Where?
How often?

Breathing and Chest **Asthma?** **Problem breathing in or out?** **Chest pain?** **Stabbing, dull ache, stuffiness?** **Back pain?** **Where?** **How often?** **Type of pain? (Dull, sharp, hot, cold, contracting)**
Any other pain in the body? **Chest** **Sides** **Abdomen** **Extremities**
Birth: **Was your birth planned?** **Were you born in hospital?** **What details do you know about your birth?**
Early childhood- any traumas or significant incidents?
Childhood illness
Other past illnesses:
Accidents, injuries, and Operations.
Drugs (which kind, how often or when)
Smoking how many:

Do you ever feel too hot? Do you ever feel too cold?
Parents / Siblings health status
Did you enjoy your childhood
How was school? Junior, senior friends
Any particular physical, mental, emotional, strains, or stresses in your childhood, teens, leaving school, college, jobs.
What has happened from leaving school until now, Relationships, children, jobs, children, stresses, and strains.
Housing – damp/ cold etc..
How is your Relationships children friends?