Main consultation form

Forms start the diagnosis; please add extra details if possible and more questions will follow. All details are kept securely in strictest confidence.

Name:	Date of Birth:	
Address:	Medication:	
Postcode:	Doctor's details Us to contact them? Y/ N	
Tel:		
Mob: Email:		
Occupation:	Marital Status:	B.P:

Main Issue:
What triggered this? How long ago?
What makes it better?
What makes it worse?
How does it limit you?
Does it cause any other problems?
How's it changed over time?
What other treatments have you had?

Please list any other issues:

<u>Digestion:</u> please use the "digestion" form if it's bad	Is your appetite good? Y / N
Do you get a sickness feeling? Y / N Is this better or worse for eating? B / W	Do you get bloating? Y / N What foods cause this?
Abdominal pain? Y / N	Pain/discomfort around ribs? Y / N
When's the evening meal?	Do your gums often bleed? Y / N
Do you get mouth ulcers? Y / N	Do you crave certain foods? Y / N
Do you get bad breath? Y / N	Do you get a strange taste in your mouth? Y / N
<u>Thirst:</u> do you sip or gulp drinks? S / G	Glass of water by the bed? Y / N
<u>Temp:</u> are you a hot or a cold person generally? H / C	Do you get cold hands & feet? Y / N
Do you get hot or sweaty at night? Y / N	Do you get hot hands and feet? Y / N

Do you tend to get warmer in the afternoon? Y / N	Do you sweat easily? Y / N
Do you get alternating hot and cold? Y / N	Abnormal sweating in one part of your body? Y / N

Sleep: do you normally sleep well? Y / N	Are you currently sleeping well? Y / N
How many hours sleep a night?	How do you feel on waking? Slow / Good
When do you get to bed? To sleep?	Do you wake during the night? Y / N
Do you get nightmares/sleepwalking? Y / N	Do you take sleeping tablets? Y / N

Energy: do you get tired easily? Y / N	A physical or mental tiredness? P / M
Energised by exercising? Y / N	Energised by resting? Y / N
Do you get an energy dip in the afternoon? Y / N	Do you get tired soon after eating? Y / N
Do your limbs feel heavy? Y / N	Do you feel better for eating? Y / N
Do you get dizzy on standing? Y / N	Do you get dizzy at other times? Y / N
Do you get breathless? Y / N	Tired & frustrated? Y / N

Pain: (also use the **"pain"** form if it's a main concern.) How long have you had it?	How does it feel?
What makes it better? (warmth, cold, pressure, moving..	What makes it worse?
What treatment have you had for it?	Do you get numbness? Y / N
Heaviness & aching? Y / N If so where?	
Lower backache? Y / N	Achy knees? Y / N
Headaches: do you get them? Y / N	How frequently?
Dull or sharp pain? D / S	Whole head or part of it? W / P

Eyes: blurred vision? Y / N	Floaters? Y / N	Weeping eyes? Y / N
Red or irritated eyes? Y / N	Dry eyes? Y / N	Glaucoma? Y / N
Ears: Tinnitus? Y / N	Deafness? Y / N	Excess wax Y / N

Bowels: how often do you go a day?	Any undigested food in stools? Y / N
Is this a regular pattern? Y / N	Colour: pale yellowy normal dark black
Consistency: hard good soft sticky	Shape: pebbly long & thin unformed
Ease: difficult easy urgent	Wind: Not much lots foul smelling no smell
Incomplete evacuation feeling? Y / N	Affected by emotional state? Y / N
Do you get blood in the stools? Y / N	Do you get mucus in your stools? Y / N
Bladder: any problems? Y / N	Do you get up to pee at night? Y / N
Urgency? Y / N	Colour: pale varies yellow
Cloudiness? Y / N	Urinary Infections? Y / N
Dribbling/leaking issues? Y / N	Erectile problems? Y / N

Skin: Do you have: acne spots dryness itching redness swelling	
Lungs: have you had: asthma pneumonia bronchitis wheezing breathlessness	
Do you often get: colds flu chestiness	Do you dislike the wind? Y / N
Do you get catarrh / phlegm? Y / N	What colour? watery white yellow green
History of recurrent coughs? Y / N	History of recurrent throat infections? Y / N

Self: do you get anxious easily? Y / N	Easily startled? Y / N
Is irritability a problem? Y / N	Do you get extended low moods? Y / N
Memory problems? Y / N	Do you get panic attacks? Y / N
Feelings of "not being with it"? Y / N	Difficulty concentrating? Y / N
Restlessness? Y / N	Awareness of your heartbeat? Y / N
Woolly-headedness? Y / N	Tight-chestedness? Y / N

Women: Please complete the 'Female form'			
Lack of libido?	Y / N	Erectile issues?	Y / N

Health History: were you a healthy child?	
Have you had an illness that keeps recurring?	
Allergies?	
Have you been prescribed steroids? Y / N What for?	
Approx how many Antibiotics courses in life? What for?	
Hospitalised? If so; when and why?	
Weekly exercise?	
Weekly units of alcohol:	No. cigarettes a day:
Any significant family illnesses?	

By completing & signing the form you're agreeing in principle to have acupuncture and/or Chinese herbal medicine. If at any time you're uncertain or uncomfortable about treatment please say so as soon as possible.

Signature: Date:

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