Crossroads Homeopathy

FIRST VISIT QUESTIONNAIRE (adult)

Please complete this form carefully and thoroughly. This information will be kept confidential.

Name .....

Date of birth: .....

Address .....

.....

Postcode .....

Home telephone no. .....

Mobile telephone no. .....

email address .....

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

General Practitioner .....

GP address .....

GP telephone no. .....

CONSENT AND ACCEPTANCE OF TERMS AND CONDITIONS

I understand that homeopathy is an alternative approach to health that involves me taking full responsibility for my health. I will not hold Dorothy Watt or Crossroads Homeopathy liable in any way for my health issues and understand they accept no liability.

I understand I should only withdraw from medication after consultation with my GP and under their supervision . I must contact my GP or Casualty Department for medical emergencies.

I understand that a cancellation charge of the full fee will apply if I fail to give at least 24 hours notice before my appointment or for non attendance.

Accepting the above provisos I request homeopathic treatment from Dorothy Watt.

Signed **Date**

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

PRESENT TREATMENT

List any current medication including vitamins, supplements etc……

List any other current treatment and complementary therapies:

MEDICAL HISTORY

List all major diseases, accidents, hospitalisations, medical treatments and traumas in chronological order. Include childhood diseases and any long term prescriptions such as birth control pill, blood pressure tablets, HRT, tranquillisers, sleeping pills etc. If you have any information about your birth or your mother's pregnancy or labour please include that as well.

Pre-birth: Any emotional / physical problems experienced by your mother during her pregnancy			
Birth: Details of your mother's labour, pain relief, interventions.			
	age	condition	treatment
Childhood illnesses:			
Accidents: Note serious ones and those which you feel are important			
Surgical procedures / major dental works: Was anaesthesia used?			
Use of drugs: Heavy / prolonged use - recreational or prescribed.			
Severe viral infections: e.g. meningitis, glandular fever etc			
Shocks/traumas: Anything which may have affected mental/emotional /physical wellbeing.			

Vaccinations: List all vaccinations, with dates, and any reactions.

Allergies: List any allergies, past and/or present with age it started / stopped.

FAMILY MEDICAL HISTORY

List all diseases of blood relations, including cause and age of death where applicable. If possible, **please include any long-term prescriptions which your mother or father were taking before your birth (eg contraceptive pill, recreational drugs)**. Please also indicate where there may be a history of alcoholism, drug addiction, behavioural problems, birth defects, disabilities or any particular condition or problem. This information is genuinely of value and will be kept confidential.

Mother	**Father**
Grandmother	**Grandmother**
Grandfather	**Grandfather**
Aunts	**Aunts**
Uncles	**Uncles**
Cousins	**Cousins**
Your Brothers and Sisters	
Your Children	

Any other information you think might be useful (please continue overleaf if necessary):