

Yakushi Centre

Healing Mind - Body & Spirit

Consultation Form

Please complete this form as thoroughly as possible. Some of the questions may seem unrelated to your condition, but they may play a major role in any treatment offered. All information is strictly confidential.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: Male Female Prefer not to say

Occupation: _____ Email: _____

Home Address: _____ City: _____

County: _____ Post Code: _____ Contact Phone: _____

Height: (if known) _____ Weight: (if known) _____

Emergency Contact: _____ Emergency Contact Phone: _____

Relationship Status: Single Married/Partner Divorced/Separated Widowed

Have you had Acupuncture/Aromatherapy/Massage/Hypnotherapy treatment before: Yes No If 'Yes', please give details:

What is/are the main problem(s) you would like help with? _____

Have you been given a diagnosis for this problem by a GP/Consultant? _____

To what extent does this problem(s) interfere with your daily life? _____

Past/Current Medical History:

<input type="checkbox"/> Cancer	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Seizures/Epilepsy
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes
<input type="checkbox"/> HIV/AIDS/Blood Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Difficulty walking standing
<input type="checkbox"/> Drug/Drink Problem	<input type="checkbox"/> Allergies	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Difficulty sitting/lying
<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney/Lung Disease	<input type="checkbox"/> Other disease	<input type="checkbox"/> STI/STD

Other (including chronic illnesses): _____

Surgery and hospitalisation: _____

Medication: _____

Allergies: _____

Are you currently Pregnant?: Yes No If 'Yes', when is the expected due date: _____

Do you exercise regularly? Yes No Do you smoke? Yes No If 'Yes' How many a day? _____

How many alcoholic drinks do you consume in a week? _____ How many cups of coffee per day? _____

Any recreational drug use? Yes No

How do you feel? Please tick all symptoms you have regularly or within the last 3 months:

Physical Condition			
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fevers/hot sweats	<input type="checkbox"/> Chills	<input type="checkbox"/> Other genital/urinary
<input type="checkbox"/> Poor sleep/Insomnia	<input type="checkbox"/> Sweat Easily	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Excessive wind
<input type="checkbox"/> Weight loss/Gain	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Bruise/Bleed easily	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Blurry vision	<input type="checkbox"/> Head aches/Migraines	<input type="checkbox"/> Bad breath	<input type="checkbox"/> Facial pain
<input type="checkbox"/> Eye pain or strain	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Poor/loss of hearing	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Earache/pain	<input type="checkbox"/> Nasal congestion	<input type="checkbox"/> Sore throat	<input type="checkbox"/> Neck stiffness
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Constipation	<input type="checkbox"/> Skin rashes	<input type="checkbox"/> Skin irritation/itching
<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Eczema/Skin problems	<input type="checkbox"/> Fungal infections	<input type="checkbox"/> Thirsty
<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Chest pain/indegestion	<input type="checkbox"/> Swelling hands/feet	<input type="checkbox"/> Any heart problems
<input type="checkbox"/> Cough	<input type="checkbox"/> Wheezing/asthma	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Abdominal pain/cramps	<input type="checkbox"/> Coughing up blood	<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Back pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Elbow pain	<input type="checkbox"/> Hand/wrist pain
<input type="checkbox"/> Foot/Ankle pain	<input type="checkbox"/> Muscle soreness/pain	<input type="checkbox"/> Hip pain	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Dribbling
Emotional Condition – Tick below if your condition/pain contributes to any of the following:			
<input type="checkbox"/> Lack of sleep	<input type="checkbox"/> Irritability	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
<input type="checkbox"/> Loss of control	<input type="checkbox"/> Harmful thoughts	<input type="checkbox"/> Violent expression	<input type="checkbox"/> Substance abuse
<input type="checkbox"/> Stressed	<input type="checkbox"/> Other emotional problem	<input type="checkbox"/> Loss of consciousness	<input type="checkbox"/> Seizures
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Lack of coordination	<input type="checkbox"/> Black outs
<input type="checkbox"/> Confusion	<input type="checkbox"/> Emotional/Tearful	<input type="checkbox"/> Hyperactivity	<input type="checkbox"/> Mood swings
Have you ever been treated for stress/depression, including counselling and or medication? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Genital			
<input type="checkbox"/> Bladder/Urine problem	<input type="checkbox"/> Pain in the groin area	<input type="checkbox"/> Other problem	
Female Only			
Gender Specific Problems:	Eg. Abdominal cramps, Pain, Sexual, Periods etc		
Male Only			
Gender Specific Problems:	Eg. Pain, Incontinence, Sexual etc		
Any Other Information which may be relevant:			

Pain

When did this condition first start? _____

How frequent is the pain? _____ How long was the pain experienced for? _____

Please **circle** the severity of your pain now on a scale of 1-10 (1 being the lowest and 10 being the most chronic pain)

1 2 3 4 5 6 7 8 9 10

Can you describe the type of pain you feel?

<input type="checkbox"/> Achy	<input type="checkbox"/> Burning	<input type="checkbox"/> Cramping	<input type="checkbox"/> Dull/heavy
<input type="checkbox"/> Numbness	<input type="checkbox"/> Pins & needles	<input type="checkbox"/> Sharp/stabbing	<input type="checkbox"/> Throbbing/pulsing

Does the pain travel or radiate out to any other area of the body? _____

Has there been an injury to this area? _____

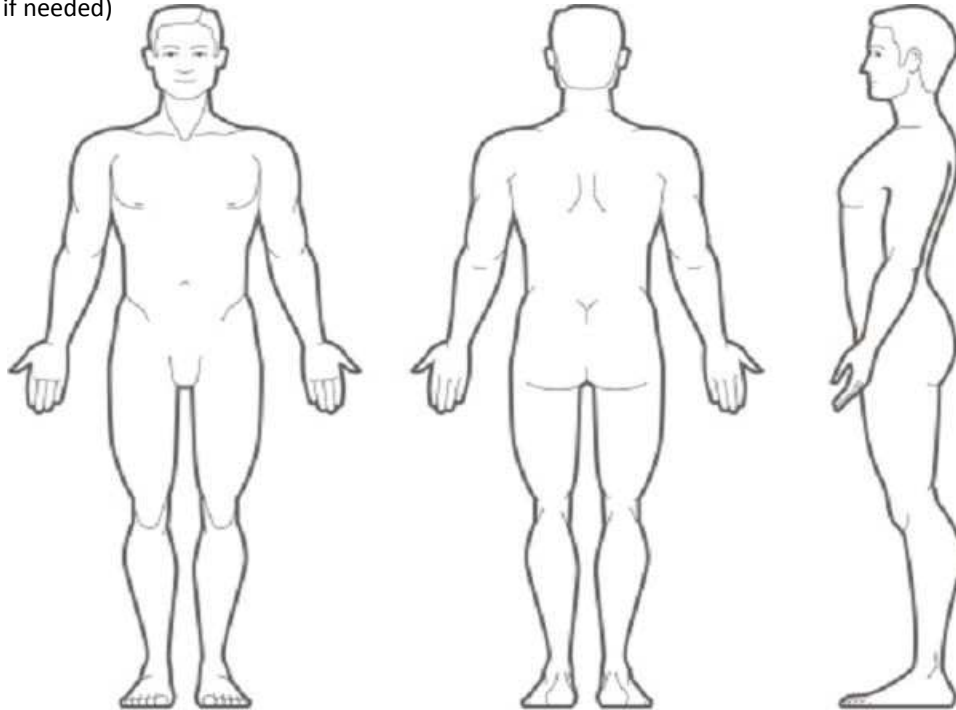
What alleviates or worsens the pain? _____

Is the pain better or worse with specific weather? _____

Is the pain better or worse at different times of the day? _____

Has there been any recent treatment for this condition, including x-rays, MRI scans and/or other tests performed? Yes No

On the diagram below please shade in the area(s) of pain (if multiple locations, write 1 next to the worst and 2 next to the least, followed by 3, 4 etc if needed)



Goals: What would you most like to achieve from the treatment(s) offered/Given? _____

Would you consider a reduction of at least 3 pain places from your original pain scale a success? Yes No

How much improved would your life be? _____

Any other queries/concerns? _____

DECLARATION: "I confirm that the information given above is correct and that to my knowledge, I have not withheld any information that may be deemed relevant to my treatment. I will notify the therapist of any future changes in my health before receiving further treatments. I accept full responsibility for any problems arising from my omissions on this form, including relevant health conditions, medications and ongoing medical treatments."

"I have been made aware and understand that Holistic/Complimentary/Alternative Treatment and/or Therapy should not substitute any Appropriate Medical advice/treatment from either a Health Professional/GP"

PLEASE NOTE: All personal information is held securely and in line with the data protection act 1998

We will not release any personal information unless:

- 1). We are required to by Law
- 2). We have your written permission to pass on any notes/treatment details to a third party. I.e. Doctor/GP/Consultant/Specialist or other health professional

Client Signature:	Date: / /
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Therapist Signature:	Date: / /
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