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: _____

Age: _____ Occupation: _____ Gender: Male ☐ Female ☐ Prefer not to say ☐

Contact Phone: _____ Email: _____

Emergency Contact: _____ Emergency Contact Phone: _____

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:

☐ Cancer	☐ High Blood Pressure	☐ Thyroid Disease	☐ Seizures/Epilepsy
☐ Arthritis	☐ Heart Disease	☐ Depression	☐ Diabetes
☐ HIV/AIDS/Blood Disease	☐ Asthma	☐ Pneumonia	☐ Difficulty walking standing
☐ Drug/Drink Problem	☐ Allergies	☐ High Cholesterol	☐ Difficulty sitting/lying
☐ Stroke	☐ Kidney/Lung Disease	☐ Other disease	☐ 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			
☐ Fatigue	☐ Fevers/hot sweats	☐ Chills	☐ Other genital/urinary
☐ Poor sleep/Insomnia	☐ Sweat Easily	☐ Loss of balance	☐ Excessive wind
☐ Weight loss/Gain	☐ Nose bleeds	☐ Bruise/Bleed easily	☐ Dizziness
☐ Blurry vision	☐ Head aches/Migraines	☐ Bad breath	☐ Facial pain
☐ Eye pain or strain	☐ Nausea/Vomiting	☐ Poor/loss of hearing	☐ Dental problems
☐ Earache/pain	☐ Nasal congestion	☐ Sore throat	☐ Neck stiffness
☐ Heartburn	☐ Constipation	☐ Skin rashes	☐ Skin irritation/itching
☐ Hair Loss	☐ Eczema/Skin problems	☐ Fungal infections	☐ Thirsty
☐ High/low blood pressure	☐ Chest pain/indegestion	☐ Swelling hands/feet	☐ Any heart problems
☐ Cough	☐ Wheezing/asthma	☐ Bronchitis	☐ Diarrhea
☐ Abdominal pain/cramps	☐ Coughing up blood	☐ Shoulder pain	☐ Rectal pain
☐ Back pain	☐ Knee pain	☐ Elbow pain	☐ Hand/wrist pain
☐ Foot/Ankle pain	☐ Muscle soreness/pain	☐ Hip pain	☐ Muscle weakness
☐ Frequent urination	☐ Urgency to urinate	☐ Pain on urination	☐ Dribbling
Emotional Condition – Tick below if your condition/pain contributes to any of the following:			
☐ Lack of sleep	☐ Irritability	☐ Anxiety	☐ Depression
☐ Loss of control	☐ Harmful thoughts	☐ Violent expression	☐ Substance abuse
☐ Stressed	☐ Other emotional problem	☐ Loss of consciousness	☐ Seizures
☐ Poor memory	☐ Loss of balance	☐ Lack of coordination	☐ Black outs
☐ Confusion	☐ Emotional/Tearful	☐ Hyperactivity	☐ Mood swings
Have you ever been treated for stress/depression, including counselling and or medication? Yes ☐ No ☐			
Genital			
☐ Bladder/Urine problem	☐ Pain in the groin area	☐ 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?

☐ Achy	☐ Burning	☐ Cramping	☐ Dull/heavy
☐ Numbness	☐ Pins & needles	☐ Sharp/stabbing	☐ Throbbing/pulsing

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

Has there been an injury to this area? _____

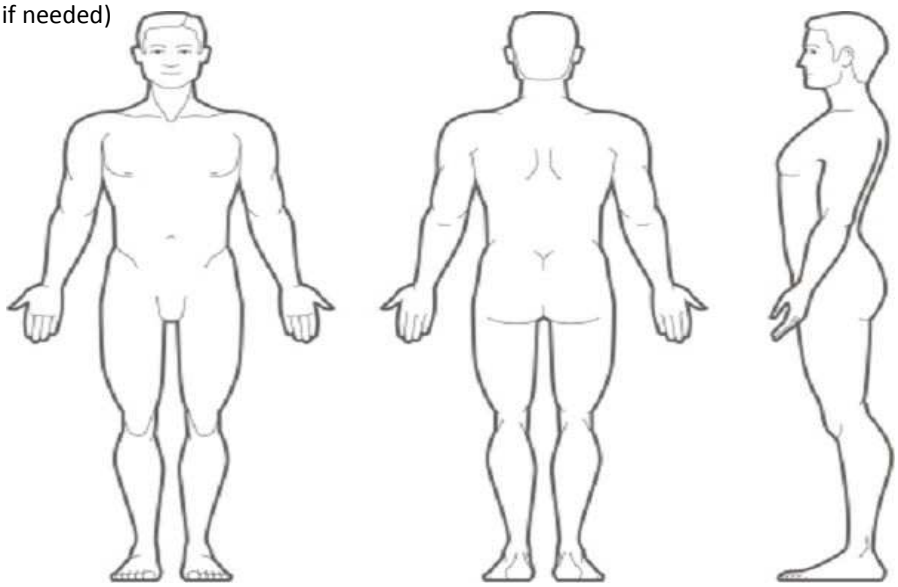
What alleviates or worsens the pain? _____

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:** / /
Therapist Signature:	**Date:** / /

***Office Use Only**

Initial Treatment Plan:	
Problem Area(s):	
Treatment:	
Any Other Information:	