

# 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:

<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:

<b>Physical Condition</b>			
<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
<b>Emotional Condition – Tick below if your condition/pain contributes to any of the following:</b>			
<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"/>			
<b>Genital</b>			
<input type="checkbox"/> Bladder/Urine problem	<input type="checkbox"/> Pain in the groin area	<input type="checkbox"/> Other problem	
<b>Female Only</b>			
Gender Specific Problems:	Eg. Abdominal cramps, Pain, Sexual, Periods etc		
<b>Male Only</b>			
Gender Specific Problems:	Eg. Pain, Incontinence, Sexual etc		
<b>Any Other Information which may be relevant:</b>			

**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? \_\_\_\_\_

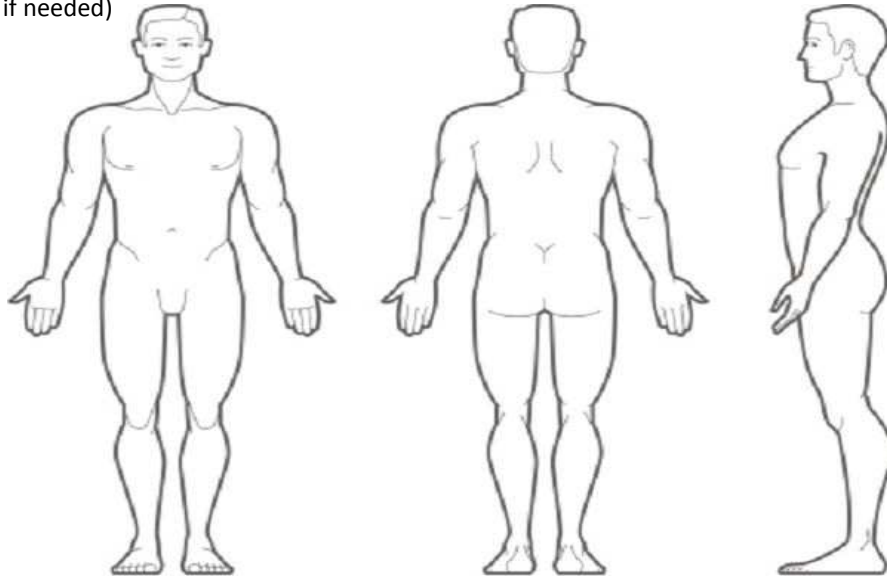
What alleviates or worsens the pain? \_\_\_\_\_

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

<b>Client Signature:</b>	<b>Date:</b> /        /
<b>Therapist Signature:</b>	<b>Date:</b> /        /

**\*Office Use Only**

<b>Initial Treatment Plan:</b>	
Problem Area(s):	
Treatment:	
Any Other Information:	