

Andrea’s Angelic Healing Centre

Menopause Consultation Form

NAME ……………………………………………………………………………………….…………..…………

DATE OF BIRTH ………………………………………………………………………..………………………..

ADDRESS ……………………………………………….………………………………………………………  
POSTCODE ……………………………………………………………………………………………...……….

MOBILE NUMBER ……………………………………………………………………………………………….

E-MAIL ADDRESS ……………………………………………………………………………………….………

DOCTOR NAME ………………………………………………………………………………………………….

SURGERY NAME ………………………………………………………………………………………………..

Occupation…………………………………………………………………………….…………..…………

Do you currently take HRT? ……………………………………………….…………..…………

**Diet**

Briefly state what your diet is like ie fruit/vegetables/meat/fish

……………………………………………………………………………………….…………..…………

Do you have sugar cravings? ………………………………………

Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Waist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hip \_\_\_\_\_\_\_\_\_\_

Do you exercise? If so, what do you do?

……………………………………………………………………………………….…………..…………

Do you eat post 8pm? ……………………………………………………………………………………….…………..…………

Do you suffer with Anxiety Y/N

Do you suffer with Depression Y/N

Do you have chest pains Y/N

Do you have any things happening at home or work that may be affecting your moods?

……………………………………………………………………………………….…………..…………

Are you experiencing problems in your sex life? Y/N

ARE YOU CURRENTLY RECEIVING ANY MEDICAL TREATMENT? Y / N

ARE YOU TAKING ANY CURRENT MEDICATIONS? Y / N

IF YES PLEASE LIST …………………………………………………………………………………..…………………………………

What do you do for pleasure/ me time/ self-love……………………………………………………………………………………….…………..…………

What do you want to improve in yourself … self-development?

……………………………………………………………………………………….…………..…………

What do you want to improve in your physical health?

……………………………………………………………………………………….…………..…………

……………………………………………………………………………………….…………..…………

……………………………………………………………………………………….…………..…………

What are your long terms goals in your emotional/physical and spiritual life?

……………………………………………………………………………………….…………..…………

Relationships? Partner? Children?

……………………………………………………………………………………….…………..…………

PLEASE SIGN AND DATE TO AGREE THE ABOVE INFORMATION IS CORRECT:

**PATIENT SIGNATURE** ……………………………………………………… **DATE** ………………………