



Healing Hands Healing Minds

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?

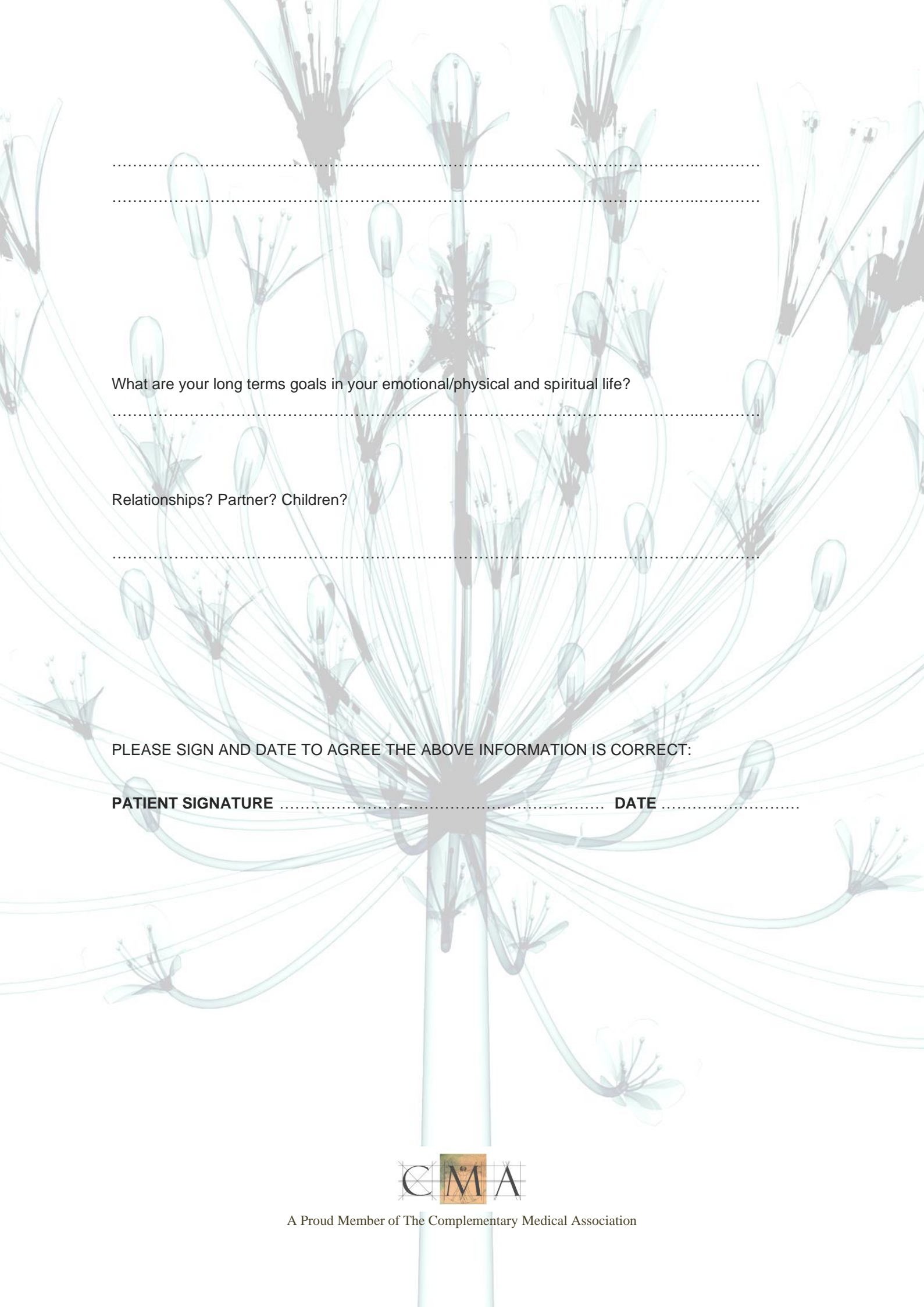
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What do you want to improve in your physical health?

.....



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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**



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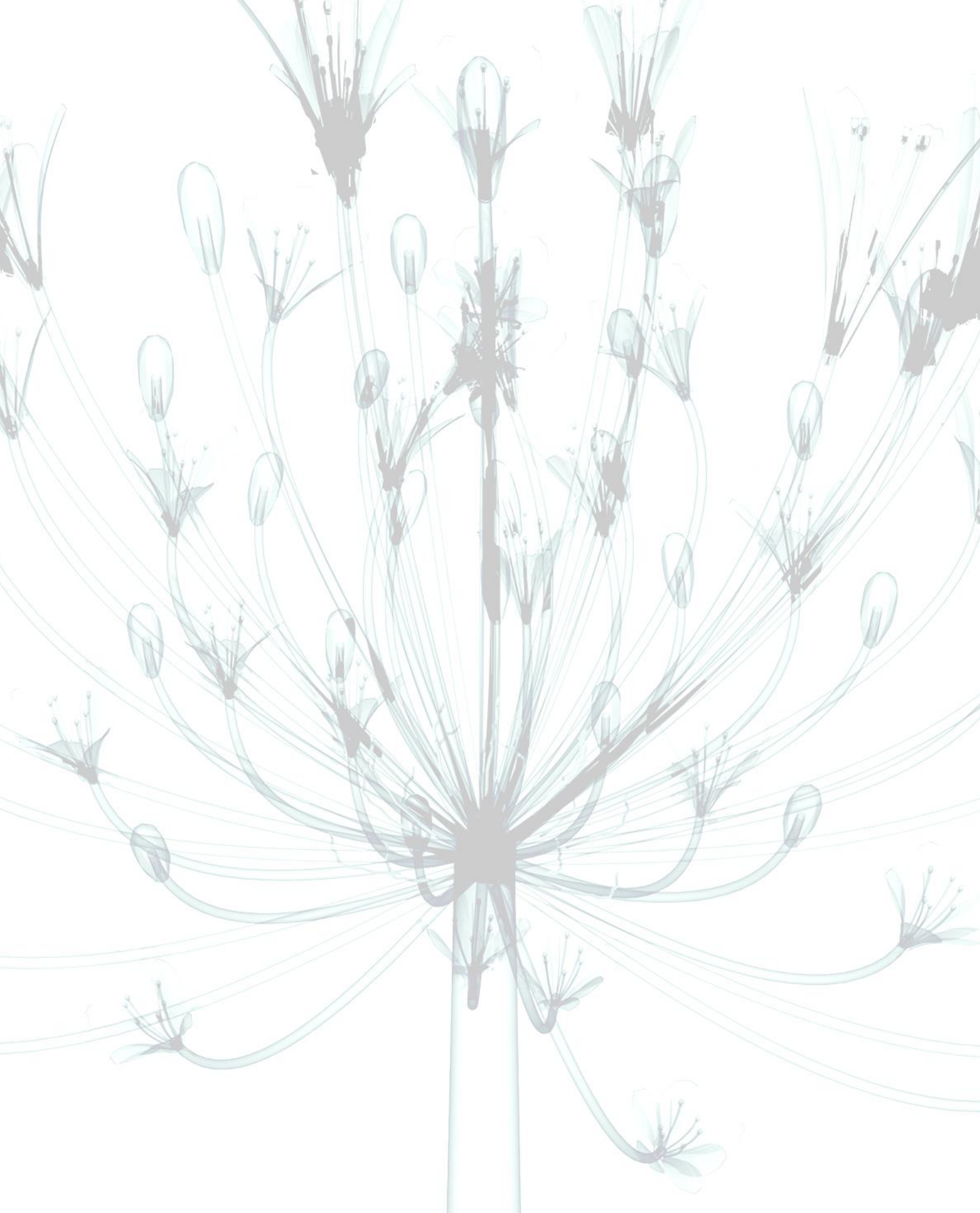
There are many symptoms to menopause, but you are not alone and I am here with you every step of your journey.

Please tick at the side of any symptoms you can relate to in your health

- ✓ Weight gain
- ✓ Difficulty concentrating
- ✓ Stress incontinence
- ✓ Brittle nails
- ✓ Allergies
- ✓ Irregular heartbeat
- ✓ Body odor
- ✓ Panic disorder
- ✓ Osteoporosis
- ✓ Hot flushes
- ✓ Night sweats
- ✓ Irregular periods
- ✓ Mood swings
- ✓ Vaginal dryness
- ✓ Decreased libido
- ✓ Headaches
- ✓ Breast soreness
- ✓ Burning mouth
- ✓ Joint pain
- ✓ Digestive problems
- ✓ Electric shocks
- ✓ Muscle tension
- ✓ Gum problems
- ✓ Tingling extremities
- ✓ Itchy skin
- ✓ Disrupted sleep
- ✓ Hair loss
- ✓ Brain fog
- ✓ Tinnitus



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