Haelan Holistics Client Form

Name-	***Address***	How did you hear about us?
Tel-	***D.O.B-*** ***M/F***	***Email***

Occupational history	
Hobbies/ sports	

		Dates
Operations		
Accidents		
Illnesses	Please fill in the tick list provided and use this space for any other conditions and extra information.	

Medication	
Doctors Name Address Tel	
Presenting conditions	
Previous treatment	

Medical Questionnaire

Do You have any of the following? Underline where applicable.	Y	N
❖ High / low blood pressure	☐	☐
❖ Thrombosis/ Embolism	☐	☐
❖ Motor nerve disorder/ MS/ parkinson's	☐	☐
❖ Epilepsy	☐	☐
❖ Diabetes	☐	☐
❖ General infection	☐	☐
❖ Eczema/dermatitis/ psoriasis/acne/boils/hives	☐	☐
❖ Sprain/strain/ bruising/fractures	☐	☐
❖ Pregnancy, if so how many weeks	☐	☐
❖ Glue ear/ tinnitus/ perforated eardrum/ merniere	☐	☐
❖ Grommets/cochlear implants	☐	☐
❖ Recent head or neck injury/concussion	☐	☐
❖ Rhinitis/sinus	☐	☐
❖ Allergies/hayfever	☐	☐
❖ Headaches/ migraines/ dizziness	☐	☐
❖ Asthma/ bronchitis/pleurisy/pneumonia	☐	☐
❖ Heart attack/ angina/stroke/ various veins	☐	☐
❖ Ulcers/IBS/ gallbladder disease/ indigestion/ jaundice/ hernia	☐	☐
❖ Kidney/ bladder/ prostate issues	☐	☐
❖ Ear/ nose/ throat issues	☐	☐
❖ Depression/anxiety/ self harm/ schizophrenia/ psychosis	☐	☐
❖ Eating disorder	☐	☐
❖ Drugs/alcohol/ other substances	☐	☐
❖ Fibromalgia/ hypermobility/ CPD	☐	☐
❖ Dental bridgework	☐	☐
❖ Slipped disc/ scoliosis/ spondylosis	☐	☐
❖ Have you taken pain relief today?	☐	☐
❖ Insomnia/sleeping disorders	☐	☐
❖ Osteoarthritis/ rheumatoid arthritis/osteoporosis/osteomalacia	☐	☐
❖ Arteriosclerosis/atherosclerosis	☐	☐
❖ Cancer/ meningitis/ brain haemorrhage/ tumours	☐	☐
❖ Contagious skin conditions/ herpes/fungus/lice/warts	☐	☐
❖ Oedema/bursitis	☐	☐
❖ Have you any mechanical implants	☐	☐
❖ Have you or anyone you live with had a temperature 37.8C +	☐	☐
❖ Have you or anyone you live with had a new or continuous cough	☐	☐
❖ Have you had any loss or smell or taste	☐	☐

Signed ……Date……..