Monkstown Natural Health

Patient History Questionnaire

Patient's Details:	
Name:	
Date of Birth:	
Address:	
Telephone Number(s):	
General Practitioner's Details:	
Name:	
Telephone Number:	
Where you heard about us:	
Date of first consultation:	
Follow up treatments:	

Monkstown Natural Health

Patient History Questionnaire

Are you pregnant ?	
Do you faint easily ?	
Are you on any blood thinning medication ?	
Operations / Hospitalisations ?	
Injuries/Accidents ?	
Allergies (pollen, foods etc.):	
Current medication & supplements:	

34 Mounttown Road Lower, Monkstown, Co Dublin. Email: info@monkstownnaturalhealth.com Tel: 086 367 9734

PATIENT CONSENT FORM

Monkstown Natural Health Clinic

I ..... (Name)

Understand that I am being seen for a Naturopathic and Acupuncture consultation and treatment by a practitioner at Monkstown Natural Health Clinic. The treatment may include inserting needles and other acupuncture techniques, moxibustion, cupping, electro-acupuncture and naturopathic advice. Treatment strategies will be discussed with the patient. The clinic would expect me as the patient to bring to their attention any issues which might prejudice treatment, such as the presence of pacemakers, infectious disease, any serious illnesses, or any impending operations.

I understand that my case will be written up for future treatment records.

Signed:	
Name (Print):	
Date:	
Address:	
Phone:	
Email:	

Patient Medical History

The following is a list of symptoms that you may or may not be experiences. Please mark any symptoms you are experiencing now or sometimes experience.

CARDIOVASCULAR		GASTROINTESTINAL		MALES ONLY	
Shortness of breath	☐	Indigestion	☐	Prostate problems	☐
High blood pressure	☐	Abdominal cramps or pain	☐	Pain in testicles	☐
Irregular heart beat	☐	Constipation	☐		
Dizziness	☐	Diarrhoea	☐	FEMALES ONLY	
Chest pain or pressure	☐	Blood in bowl movement	☐	Pre menstrual pain	☐
Leg cramps	☐	Black bowl movement	☐	Pain with period	☐
		Excess appetite	☐	Irregular menstruation	☐
RESPIRATORY		Decreased appetite	☐	Breast swelling or pain	☐
Cough	☐	Excess Thirst	☐		
Cough up blood	☐	Nausea or Vomiting	☐	MISCELLANEOUS	
Sore throats	☐	Colitis or Divirticulitis	☐	Jaundice	☐
Nasal problems	☐	Heart burn	☐	Hepatitis	☐
Asthma or Wheezing	☐	Belching or burping	☐	Memory loss	☐
Pneumonia	☐	Gall Stones	☐	Hearing loss	☐
Hay fever	☐			Ringing in ears	☐
Bronchitis	☐	GENITOURINARY		Headaches	☐
Catches cold easily	☐	Frequent urination	☐	Sore or dry eyes	☐
		Painful urination	☐	Insomnia	☐
SKIN		Vaginal discharge	☐	Fever	☐
Ulceration's	☐	Venereal disease	☐	Chills	☐
Rash	☐	Pain in genital area	☐	Night sweats	☐
Oedema	☐	Decreased sex drive	☐	Day sweats	☐
Acne	☐	Kidney stones	☐	Intolerance to weather change	☐