Nicky Lee homœopath & nutritionist

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Please take time to complete this form and bring it with you to your first consultation. Date _____

Name _____ Date of Birth _____

Address _____

Email _____ Home tel _____ Mobile _____

Occupation _____ Name & Tel number of GP _____

Calibration of Health - on a scale of 1 to 10 (1 being poor and 10 being excellent) how do you feel:

Emotionally _____ Physically _____ Energetically _____

Presenting Complaint [the condition/s you would like help with] _____

_____

_____

_____

Have you ever had any of the following? If you have, please give details and dates if possible:

Head injuries, headaches, migraines, etc _____

Ear, nose, throat problems (glue ear, tonsillitis) _____

Allergies / sensitivities (food, hay fever, hives, prickly heat) _____

Skin (eczema, dermatitis, psoriasis, warts, verrucas) _____

Breathing (asthma, bronchitis, pleurisy) _____

Cardiac (arrhythmia, high blood pressure, high cholesterol) _____

Digestive problems (heartburn, eating disorders, wind, bloating)_____

Bowels (diarrhea, constipation) - do you pass a stool daily? _____ If not how often? _____

Are your stools ever loose, hard, contain mucous or undigested food? _____

Reproductive system (periods, fertility, menopause, thrush)_____

Urinary (cystitis, bedwetting, involuntary) _____

Musculoskeletal (back, joints) _____

Accidents, stays in hospital _____

Present medication - drugs / contraceptive pill / HRT / steroids / inhalers / antihistamine etc _____

_____

_____

Have you had any previous homoeopathic or nutritional treatment, please give details? _____

_____

Vaccinations [please include ages/dates and any reactions] _____

_____

Do you have any silver amalgam (grey) fillings, root canals, crowns, how many? _____

Do/have you ever suffered from bleeding gums, mouth ulcers? _____

Have you ever suffered from Athlete's foot, Thrush, Cystitis, Fungal nails, Bloatedness, Fuzzy memory?

(please circle any/all)

How much tea/coffee/alcohol/fizzy drinks consumed per day?_____ Amount of water drunk per day?_____

Do you drink alcohol? How many units a week?_____ Do you or have you ever smoked?_____

How much time spent using a computer / watching TV?_____ Hours per week using a mobile phone ?_____

Do you use a microwave, how often? _____ Recreational drugs taken _____

Do you dye or perm your hair? _____ Do you use a lot of make-up, nail varnish, deodorants?_____

Do you take any form of exercise? Please indicate what kind and how often _____

_____

How long have you lived at your present address and are you happy there? _____

Do you sleep well?_____ Do you wake up during the night? Any specific time/s?_____

Do you wake refreshed? _____ Have you ever have nightmares? _____

Do you or have you ever suffered from anxiety, depression, panic attacks, phobias? Please give details____

_____

_____

Have you had any major shocks or traumas in your life? Please give details _____

_____

_____

Details of your birth (natural delivery, c-section, breastfed)? _____

Childhood development & illnesses _____

_____

_____

Family Medical history

This information is very important.

Please list any serious illnesses, long-term health issues in your family and cause of death if appropriate.

Mother's side	**Father's side**
Mother _____	Father _____
Mother's mother _____	Father's mother _____
Mother's father _____	Father's father _____
Mother's sisters _____	Father's sisters _____
Mother's brothers _____	Father's brothers _____

Sisters _____

Brothers _____

Own children _____

Nephews & Nieces _____

Cousins _____

Diet and Digestion

Do you eat regularly?(3 main meals & 2 snacks)_____

Do you use organic products?_____ Do you crave any particular food or taste?_____

Do you prepare all meals from fresh ingredients? _____

How many take away meals will you eat per week? _____ How many times a week will you eat out?_____

Do you eat quickly or slowly?_____ Do you ever feel light-headed if you do not eat regularly? _____

Do you regularly eat on the move? _____ Do you ever miss meals? _____

Do you add salt to your food? _____ Do you add sugar to your drinks? _____

In order to be able to help you to optimize your diet please be honest when filling in the food & drink diary below. Please give details of all meals, snacks, treats and drinks, including water & alcohol, in as much detail as possible. It is also helpful to note O for organic produce and PP for pre-prepared/shop bought items.

DAY 1	Time	Details of food & drink consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DAY 2	Time	Details of food & drink consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DAY 3	Time	Details of food & drink consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DAY 4	Time	Details of food & drink consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		

DAY 5	Time	Details of food & drink consumed
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		