the westoe practice
a centre for health and wellbeing

Total Health Programme

Please hand this form in to the practice reception and a free consultation will be scheduled.

Name ____ Date______________

Address____

Postcode__________________ E-mail Address ______________________________

Phone number / Mobile ___________________________ Date of Birth_________________

What is your weight? _______stone _______lbs. What is your height? ________feet _______inches

Occupation___________________________ Hobbies / Recreation___________________________

How did you hear about the practice? ____

Please list the health problem(s) you would like to resolve: ___________________________________

____

____

Under what circumstances do these problems improve? ________________________________

Under what circumstances do these problems get worse? ______________________________

Do you regard your health problem(s) to be; Severe ☐ Moderate ☐ Mild ☐

What other forms of therapy have you used to resolve your health problem (s)? _________________

____

How successful were they? Very successful ☐ partly successful ☐ Not successful ☐

Please list previous/other illness/accidents/surgery that you have had: _________________________

____

Please list any medication you are currently using: ____________________________________

____

In what way do you expect your health problem (s) to improve with natural therapies?

____

Over what period of time do you expect total recovery to occur? ____________________________

Please list any supplements you are currently taking (Vitamins, minerals, fatty acids, amino acids, anti-oxidants): ____

____

What is your daily water intake? (not including fruit juices, soft drinks, tea, coffee, alcohol)

2.5 litres ☐ 2 litres ☐ 1 litre ☐ 500ml ☐ less ☐

Briefly describe your diet: ____

____

____

On average how much alcohol do you drink in a week? ____________________________________

Are your bowel movements: Daily ☐ less than daily ☐

How often do you exercise? Daily ☐ weekly ☐ occasionally ☐ never ☐

On a scale of 1 – 10 what is your energy level? ____

Do you smoke cigarettes? If so how many per day? ____

Do you use orthotic appliances in your shoes? Yes ☐ No ☐

Do you wear a pace maker? _____________________ Have breast implants? _____________________

Do you experience back pain, neck pain or other physical pain? ______________________________

Do you experience ringing in the ears, clicking/popping of the jaw or facial pain? ___________________

If you are female: Are you pregnant? _______________ If yes, how advanced? __________________

Menstrual cycle: regular ☐ irregular ☐ painful ☐ heavy ☐ menopausal ☐ other ☐

Do you have any children? If so state age and gender ____

How many brothers and sisters? If so state age and gender ____________________________________

Are there any particular illnesses that they suffer from? ______________________________________

What illnesses was your mother prone to? ____

What illnesses was your father prone to? ____

Please tick any of the following issues, which relate to you and place two ticks against those you would like to resolve or improve;

Nervousness	Depression	Fears	Shyness
Sexual problems	Suicidal thoughts	Separation	Divorce
Finances	Drug use	Alcohol use	Friends
Anger	Self control	Unhappiness	Sleep
Stress	Work	Relaxation	Headaches
Tiredness	Legal matters	Memory	Ambition
Energy	Insomnia	Loneliness	Education
Concentration	Making decisions	Temper	Nightmares
Career choices	Inferiority	Marriage	Children
PMS	Unpleasant memories	Thoughts	Parenting
Pain	Enemies	Social skills	Motivation
Regrets	Anxiety	Dizziness	Grieving

Do you have any other goals or concerns? If so please briefly explain: ____________________________

____

Nb: This information will form the basis of your consultation and under the data protection act 1998 will not be disclosed to any third parties.

Dean Glozier BSC HONS MCHS HPC reg and associates.
1a elizabeth st, south shields tyne and wear ne33 4pj tel. 0191 4250101