M D Pook **T/A The Castle Clinic**

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HOMEOPATHIC & RADIONIC PRACTITIONER

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NEW PATIENT QUESTIONNAIRE (ADULT)

SECTION 1

SURNAME _____ INITIALS _____MR/MRS/MISS

ADDRESS _____ FIRST NAME _____

_____ TEL(Home/Mob) _____

_____ EMAIL_____

POSTCODE _____ OCCUPATION _____

AGE _____ DATE OF BIRTH _____ HEIGHT __ft __in WEIGHT __st __lb

Who recommended the clinic to you?_____

Who is your doctor and where is the practice?_____

List all medicines you are taking:_____

_____

Are you receiving any other kind of treatment?_____

DECLARATION: I understand that Homeopathy is a safe complementary system of medicine & it works gently to stimulate the body's own healing power.

I understand that there is no recommendation by the Homeopath to stop, vary, reduce or change any medication prescribed by my G.P. and/or Consultant and if I intend to do so, that will be at my own choice and my concerned Homeopath will not be liable for any consequences thereof.

Signature _____ Date _____

PLEASE NOTE: This questionnaire has been designed to help us evaluate how we may be able to help you with your condition. To accomplish this, we ask that you answer each question carefully and honestly on the next pages. If, for any reason, it is considered that your condition is not one which can be helped by the type of treatment we offer, this will be explained and advice will be offered about more suitable measures that you should consider.

ALL INFORMATION IS RETAINED IN ACCORDANCE WITH GDPR & OUR PRIVACY POLICY

SECTION 2

To be completed if you are seeking homoeopathic treatment (continue on other side if necessary)

Describe your present complaint or complaints and their history, and any stresses you are under at the present time.

What other complaints, illnesses or operations have you had in the past?

How would you describe your temperament and personality?

Please indicate what you feel were the chief pressures brought to bear on you in your childhood. If possible, give some indication as to whether you consider your childhood to have been a happy one.

SECTION 3 (Not applicable to infants)

HOMOEOPATHIC / RADIONICS QUESTIONNAIRE

IN GENERAL: (please delete YES or NO, or tick the appropriate boxes)

1 Do you generally feel anxious? YES/NO

2 Are you easily offended? YES/NO

3 Do you suffer any lack of self confidence? YES/NO

4 Are you jealous or suspicious? YES/NO

5 Do you always feel in a hurry to get things done? YES/NO

6 Do you relate well with work colleagues? YES/NO

If not, why not?_____

7 Do you lack energy? YES/NO

8 Do you catch cold regularly? YES/NO

9 Is there any time of day when you feel worse in yourself ? For example:-

Morning ❑ Afternoon ❑ Late afternoon ❑ Evening ❑

10 Do your problems occur periodically? For example:-

Daily ❑ Monthly ❑ Every full moon ❑

11 Can you get off to sleep OK? YES/NO

12 Do you wake regularly in the night at any special time? YES/NO

If so, at what time(s)? _____

Is there a reason you are aware of?_____

13 Do you regularly adopt a particular posture when you sleep? YES/NO

If so, what posture?_____

14 Describe any particular dream you get or type of dream on a regular basis:_____

_____

15 Do you readily feel the cold and feel you have to wrap-up well? YES/NO

16 Do tight, close-fitting clothes make you feel uncomfortable? YES/NO

17 How are you affected:

a) by the cold? _____

b) by the heat? _____

c) by the wet? _____

d) by thunderstorms? _____

e) by crowded places? _____

f) by the seaside? _____

g) by physical activity? _____

h) by sleep? _____

18 Do extremes of temperature upset you? YES/NO

19 Do you prefer the fresh air to being indoors? YES/NO

20 Do you have: a) cold hands? YES/NO
b) cold feet? YES/NO

21 Do you find yourself wanting to be on your own a lot? YES/NO

22 Do you get depressed or gloomy? YES/NO

23 Are you irritable or quarrelsome? YES/NO

24 Do you have any fears or phobias? YES/NO

If so, what are they? _____

25 Are you over-conscientious about details, eg. cleanliness, punctuality? YES/NO

26 Do you suffer from any bottled-up anger, resentment or regret? YES/NO

27 Is your <u>main</u> interest in people ❑ , ideas ❑, or practical matters ❑ ?

28 Are you very affectionate? YES/NO

29 Do you cry easily? YES/NO

If so, what makes you cry?_____

30 Do you consider yourself a private person, generally keeping your thoughts and feelings to yourself? YES/NO

31 What is your memory like? _____

32 Can you think clearly? YES/NO

33 How much liquid do you drink in a day? _____

34 How much tea/coffee do you drink in a day? _____

35 Does your mouth tend to be dry? YES/NO

36 As a general rule do you prefer hot drinks rather than cold drinks? YES/NO

37 Name any foods that cause discomfort, eg. headache, heartburn, wind?_____

_____

38 Is your appetite:- normal ❑ , ravenous ❑ , absent ❑ , OK until you start to eat ❑

39 Name any special cravings you have in the food line:- _____

_____

40 Do you like or dislike the following (delete as appropriate): -

Salty things: LIKE / LIKE VERY MUCH / DISLIKE / DETEST

Sweet things: LIKE / LIKE VERY MUCH / DISLIKE / DETEST

Fatty foods: LIKE / LIKE VERY MUCH / DISLIKE / DETEST

Savoury foods: LIKE / LIKE VERY MUCH / DISLIKE / DETEST

41 Do you suffer from indigestion:-

a) immediately after eating? YES/NO
b) an hour or so after eating? YES/NO

42 Do you suffer from flatulence ❑, feel bloated ❑, or the need to belch ❑ ?

43 Do you have an unusual taste in the mouth? YES/NO

If so, how would you describe it? _____

44 Is your tongue coated? YES/NO

If so, what is the colour? _____

45 Do you have a strong aversion to any particular foods? YES/NO

If so, what are they? _____

46 Have you consumed food cooked in aluminium over a period of time? YES/NO

47 Are bowel movements regular? YES/NO

48 Do you have a normal desire to pass stool? YES/NO

49 Is the stool:

a)	light?	❑
b)	dark?	❑
c)	mucus covered?	❑
d)	streaked with blood?	❑
e)	in pellets?	❑

50 Have you been unwell ever since some particular incident in the past, for example:-

Vaccination ❑

Emotional Shock ❑

Physical Injury ❑

Any particular illness ❑

51 Do your glands tend to swell? YES/NO

52 If you suffer from catarrh/sinusitis:-

Does it come away? YES/NO

Does it come away at any particular time? YES/NO

If so, when? _____

Is the discharge clear ❑ , sticky ❑ , yellow ❑ , green ❑ ?

Does it tend to drop into the throat? YES/NO

53 If you have any skin condition:-

If it is a rash, what is the rash like? _____

Where does it appear? _____

Does it itch ❑ , or burn ❑ ?

Does scratching aggravate it? YES/NO

Has it been diagnosed as eczema ❑ , fungal infection ❑ , psoriasis ❑ , or anything else ❑ (please state)_____

54 Do you have warts ❑ , moles ❑ , excessive scar tissue ❑ , falling hair ❑ , early greying hair ❑ ?

55 Do wounds take a long time to heal? YES/NO

56 Do you perspire a lot? YES/NO

Do you perspire on a particular part of the body only? YES/NO

If so, where?_____

Does the perspiration smell ❑ , or stain ❑ ?

Is the perspiration cold ❑ , or hot ❑ ?

57 Have you ever suffered trauma of a sexual nature: Male/Female - rape ❑ , any sexually transmitted disease ❑ ? Female - miscarriage ❑ , abortion ❑ ?

58 Female - are periods early ❑ , late ❑ , heavy ❑ , painful ❑ , absent ❑ , scanty ❑ , clotted ❑ ,irregular ❑ ?

59 Female - what PMT symptoms do you suffer, if any? _____

_____

FAMILY

60 Are you aware of any illnesses associated with close relatives (eg. eczema, allergies, arthritis, diabetes, circulatory problems, heart disease, mental disorders)?

_____

_____

_____

Please return your completed questionnaire, together with a SMALL snipping of hair to:

Mr M D Pook
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