

**Personal details:**

Name:

Age:

Address:

Tel no:

Email:

(If it is ok I will add you to our mailing list for our quarterly news letter)

Job:

Children (how were their births):

Work postures:

Sports:

**Presenting complaint:**

Site:

How did it start:

When did it start:

Pain scale out of 10 (10 worst):

Things that make the pain worse:

Things that make the pain easier:

Have you seen any practitioners already:

What did they do and did it help:

Is there any morning/evening pattern to your pain.

**Past injury history (with approximate dates) Please fill this in with everything from birth:**

Feet:

Ankles (including ankle sprains):

Lower legs:

Knees:

Upper leg and groin:

Pelvis and viscera:

Lower back and sacrum/coccyx:

Mid back and ribs:

Shoulders:

Elbows:

Wrists:

Neck:

Head (any bangs/impacts):

Eyes (including vision):

Teeth (including dental work, clicking and grinding):

Operations and surgery:

Scars (all important):

Broken bones:

Piercings tattoos:

Accidents (including road traffic accidents, whiplash, falls onto tail bone, concussions and falls):

**Systemic health:**

How is your general health:

Current Medication:

Past medication:

Have you ever had an X-ray/MRI or other investigations and what were they for:

Do you suffer from night sweats, unexplained weight loss, unremitting pain that stops you sleeping:

Your birth details:

Childhood illness:

Hospitalisations:

Cardiovascular health:

Respiratory health (any shortness of breath, asthma, pneumonia etc.):

Digestion (any reflux, blood in stools etc.):

Gynaecological health (smear tests etc.):

Neurological (headaches, dizziness, loss of sensation or strength):

Alcohol/smoking/drugs:

Stress levels:

Anxiety levels:

Have you ever been diagnosed with cancer:

Have you ever had your bone density levels measured:

Any other medical conditions:

**Functional health**

IMMUNE SYSTEM

1). Have you ever been diagnosed with an autoimmune disease? Please specify

2). Have you ever had asthma, allergies or acid reflux? Please specify when

3). Have you ever been diagnosed with a virus? When were you diagnosed? (i.e. Mono, Epstein-Barr, Herpes, chickenpox/shingles?)

4). When stressed, do you experience: cold sores, hives, shingles or chronic fatigue?

5). Were you a natural birth or a c-section?Where you breast fed or bottle fed?

HORMONE

1). Any sleep disturbances?

2). When you wake up in the morning do you feel energized or do you feel you want to sleep longer?

3). Do you feel tired regardless the amount of hours you sleep?

4). Do you get cravings for sugar OR salt? Please specify

5). Do you have difficulty losing and/or gaining weight regardless of diet/exercise regimen you follow?

THYROID

1). Do you get cold hands/feet?

2). Do you easily gain weight?

3). Do you experience constipation?

4). Do you have history of high cholesterol?

OESTROGEN (for Females)

1). Have you ever been diagnosed with PCOS? Fibroids? Endometriosis?

2). Do you have history of migraines?

3). Do you experience hair loss? Low sex drive? Hot flashes?

4). Have you experienced irregular menstrual cycles?

5) Are you getting hair in unwanted places, face, chin, body?

BLOOD SUGAR

1). Have you ever been diagnosed with Diabetes?

2). Do you frequently get thirsty?

3). Do you frequently feel the urge to urinate?

4). Do you feel tired/fatigued after a meal? OR Do you feel energized after a meal?

5). Do you feel "hangry" in the morning before breakfast? (Hungry and angry)

TESTOSTERONE (for Males)

1). Do you urinate frequently and/or have difficulty urinating?

2). Do you suffer from baldness?

3). Do you have difficulty gaining muscle weight when working out?

4). Do you have difficulty losing weight?

5). Do you experience low sex drive?

DIGESTION

1). Do you experience gas and/or bloating after eating?

2). How do you feel after taking probiotics? Any problems?

3). Have you been diagnosed with stomach ulcers or gastritis? SIBO (*Small Intestinal Bacterial Overgrowth)*? Candida? Depression? ADHD?

4). Do you experience skin itching/irritation frequently?

5). Have you recently been experiencing food sensitivity/allergies to food not previously experienced?

6). Do you have any skin conditions? (i.e. psoriasis, eczema, rosacea, acne, etc.)

7) Do you tolerate alcohol badly?

8) How do you feel after taking Kombucha tea?

GENERAL

2). List of supplements.

a). What do you take them for?

b). Do they help you with your symptoms?

What are your expectations from treatment?

Thank you for taking the time to fill in the form.  If you could send it back to me at dan@danielbaines.co.uk  in advance of our appointment so I can start working on your timeline it would be much appreciated.

Best wishes

Dan