***Consultation Intake Form @ Well Being Dublin***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Todays date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Services found by*: Former client / Internet Search engine/ Social media/ Other (circle)

\* **Reason for visit**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How long have you had this condition? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does it impact upon your: Sleep / Work / Other (Describe briefly)

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What seemed to be the initial cause? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What seems to make it better/ worse? (e.g. heat, cold, damp, wind, hunger, rest, exercise, stress)

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Other concurrent therapies (e.g Physiotheraphy, talk therapy) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medications -** Add the \*Name \*Dose \*Frequency \*Duration taking \*Reason (e.g. Painkilling)

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***Family* Medical History**:

 (Circle where relevant)

Allergies Asthma Arthritis Cancer Depression

Diabetes Heart disease Stroke \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Your* Medical History**:

 (Circle those that are a significant part of your medical history)

Aids/HIV Allergies Appendicitis Arthritis Bleeding disorder T.B.

Cancer Chicken Pox Diabetes Epilepsy Heart Disease

Hepatitis Measles Mono Pneumonia Rheumatic Fever

Scarlet Fever Seizures Anemia Thyroid Depression Panic attacks

Surgery / Medical Injury (inc. root canals, ‘silver’ fillings, cosmetic surgery, vaccine injury: (List)

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Other (e.g. Car accident, major physical/emotional trauma,) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Food and Drink:

Appetite: (small/normal/large) Tea/Coffee Artificial sweetener Sugar (spoons?) \_\_\_

Thirst for water: (glasses per day) \_\_\_\_\_\_\_\_\_\_ Sip or gulp fluids Soft drinks: \_\_\_\_\_\_\_\_\_\_

Craving for particular food taste (e.g. sugary/salty) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Vegetarian/ Vegan/ Restricted dietary programme ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Lifestyle / Environment**

Tobacco Alcohol Drugs Occupational hazards Home refurbishment

Exercise/type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Stress Level (Low/Medium/High/Very high)

**\*Current Supplements:**  (herbs/vitamins/homeopathic remedies etc.)

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**General Symptoms:**

Tiredness Prefer cold drinks Prefer hot drinks Recent weight loss/gain

Difficulty *getting* to sleep Difficulty *staying* asleep Nightmares Fever Chills Lack

of strength Bodily heaviness Cold hands/feet Perspiration of hands/feet/underarms

Night sweats Muscle cramps Vertigo or dizziness Bruise easily Peculiar taste in mouth

*Which of the following do you tend to feel physically?*  Warm Hot Average Cool Cold

**Head, eyes, ears, nose & throat:**

Eye dryness Eye pain Red eyes Itchy eyes Glasses Cataracts Spots in Vision

Poor vision Blurred vision Night blindness Glaucoma Grinding teeth Teeth problems

TMJ Facial Pain Gum problems Sores on lips Dry Mouth Excessive saliva

Sinus Swollen glands Lumps in throat Phlegm (Colour of phlegm) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Thyroid problem Recurrent sore throat Nose bleeds Poor hearing Earaches

Ringing in Ears/ Tinnitus Headaches Migraines Concussion

**Respiratory:**

Cough Difficulty breathing Wheezing Shortness of breath

Tight Chest Asthma Pneumonia Recurrent colds

**Cardiovascular:**

Heart Palpitations /fluttering Chest pain Phlebitis High / Low blood pressure

History of blood clots Irregular heartbeat Difficulty breathing

**Gastrointestinal:**

Nausea Vomiting Acid reflux Gas Bloating Diarrhea

Constipation Laxative use Bloody stools Mucous in stools Loose stool

Intestinal pain or cramping Itchy/burning anus Rectal pain Hemorrhoid

Bowel movements:

Frequency: (times per day or week) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Color: (e.g. Pale/V.Dark /Green tinged) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Texture/Shape (e.g Soft, Very Dry, Pencil/ Banana shape, Pellets) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Odor: (strong OR mild) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Musculoskeletal:**

Neck pain Shoulder pain Muscle pain Upper/Lower back pain Joint pain

Knee pain Limited range of motion Limited use Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin and Hair:**

Rashes Hives Ulcerations Eczema Psoriasis Acne Dandruff

Itching Hair loss Change in hair/skin texture Fungal infections

**Neuropsychological:**

Poor memory Depression Manic depression Anxiety Irritability Easily stressed

Easily angered Seizures Panic attacks P.T.S.D Numbness Head fogginess

**Genito-urinary**

Pain on urination Frequent urination Urgent urination Blood in urine

Unable to hold urine Incomplete urination Bedwetting Wake to urinate

Increased libido Decreased libido Kidney stone E.D. S.T.I

Colour of urine - pale/medium/dark

**(*In the next chart, no need to use coloured pens:*)**

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**Gynecology:**

Age menses began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Length of cycle (day1 to day1) \_\_\_\_\_\_\_\_\_\_\_\_\_ Duration of flow (e.g. 28 days) \_\_\_\_\_\_\_\_\_\_\_\_

Irregular periods Painful periods Clots

PMS Vaginal discharge (colour) \_\_\_\_\_\_\_\_\_\_\_\_

Vaginal sores Contraceptive use \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Breast lumps

# Pregnancies \_\_\_\_\_\_\_\_ # Children \_\_\_\_\_\_\_\_ Breastfeeding Y / N

Date last period began: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age at menopause: \_\_\_\_\_\_\_

**Other health history not mentioned:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Professional Use:**

Tongue \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pulse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Treatment programme \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Selected Points \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **Tongue sketch**  **QI**  **BL**

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