

History/ Symptom Worksheet

Mr/Mrs/Miss/Master/Ms/Other.... .. Date of birth.....

Full name.....

Address.....

.....

.....Postal Code.....

.....

Age.....Height.....Weight.....Occupation.....

.....

Telephone Nos:

Home.....Mobile.....Work.....

E-mail

.....

Medical Aid Society/ Insurers (name).....Membership No:

.....

PREDISPOSING HISTORY (use additional paper, if necessary)

Surgery, el. therapy, etc (give approx dates) Serious Illnesses (give approx dates)

Date of last visit to osteopath/ chiropractor/ physiotherapist (which?)

.....

Ever had a diagnosis of (please circle): kyphosis, lordosis, osteoporosis, scheuermann's scoliosis?

List the nutritional supplements you are taking at present:

Areas of stress:

In marital (or other) relationship? YES /NO /SOMETIMES
At home? YES /NO/ SOMETIMES
At work? YES /NO /SOMETIMES
Elsewhere? (where?) YES /NO /SOMETIMES

Are you a vegetarian, omnivorous, or vegan? (please circle)

Complete history of antibiotics:

Complete history of other medications/drugs:

SYMPTOMS

Please circle a number below, indicating the severity of current symptoms, e.g. circle zero (0), if the symptom is not present, or any number up to six (6) – extremely severe. Please circle only one number per symptom, and only indicate the present (current) rating for each.

- | | |
|---|---------------|
| 1) Craving for sweet foods | 0 1 2 3 4 5 6 |
| 2) Chronic fatigue or lethargy | 0 1 2 3 4 5 6 |
| 3) Cry easily for no apparent reason | 0 1 2 3 4 5 6 |
| 4) Frequent mood swings | 0 1 2 3 4 5 6 |
| 5) Faintness or shakiness when meal delayed | 0 1 2 3 4 5 6 |
| 6) Irritable before eating | 0 1 2 3 4 5 6 |
| 7) Lacking confidence | 0 1 2 3 4 5 6 |
| 8) Poor co-ordination | 0 1 2 3 4 5 6 |
| 9) Dry mouth/throat | 0 1 2 3 4 5 6 |
| 10) Neck or shoulder pains | 0 1 2 3 4 5 6 |
| 11) Pain in ribs or thoracic spine | 0 1 2 3 4 5 6 |
| 12) Mid-back pains | 0 1 2 3 4 5 6 |
| 13) Low-back pains | 0 1 2 3 4 5 6 |
| 14) Pain in sacrum or coccyx | 0 1 2 3 4 5 6 |
| 15) Pains in the skull | 0 1 2 3 4 5 6 |
| 16) Sleepy after meals | 0 1 2 3 4 5 6 |
| 17) Difficult to lose weight | 0 1 2 3 4 5 6 |
| 18) Increasing weakness | 0 1 2 3 4 5 6 |
| 19) Acute anxieties/depression | 0 1 2 3 4 5 6 |

20) Frequent headaches/migraine	0 1 2 3 4 5 6
21) Dry, coarse skin/hair	0 1 2 3 4 5 6
22) Profuse sweating	0 1 2 3 4 5 6
23) Sinus congestion	0 1 2 3 4 5 6
24) Brittle or flaking nails	0 1 2 3 4 5 6
25) Poor sexual performance/loss of libido	0 1 2 3 4 5 6
26) Increasing frustration	0 1 2 3 4 5 6
27) Panic attacks	0 1 2 3 4 5 6
28) Constipation	0 1 2 3 4 5 6
29) Diarrhoea	0 1 2 3 4 5 6
30) Abdominal bloating with food	0 1 2 3 4 5 6
31) Burning in stomach after eating	0 1 2 3 4 5 6
32) Indigestion or trapped wind	0 1 2 3 4 5 6
33) Belching and wind	0 1 2 3 4 5 6
34) Haemorrhoids (piles)	0 1 2 3 4 5 6
35) Allergic reaction to foods	0 1 2 3 4 5 6
36) Mucus (sliminess) in stools	0 1 2 3 4 5 6
37) Stools light in colour	0 1 2 3 4 5 6
38) Rashes, acne, eczema	0 1 2 3 4 5 6
39) Bruise easily	0 1 2 3 4 5 6
40) Athlete's foot	0 1 2 3 4 5 6
41) Anal itch	0 1 2 3 4 5 6
42) Fungal infection of skin or nails	0 1 2 3 4 5 6
43) Cold hands and/or feet	0 1 2 3 4 5 6
44) Night sweats	0 1 2 3 4 5 6
45) Pain, swelling in joints	0 1 2 3 4 5 6
46) Dark circles under eyes	0 1 2 3 4 5 6
47) Numbness, tingling in arms/legs	0 1 2 3 4 5 6
48) Pre-menstrual tension	0 1 2 3 4 5 6
49) Persistent thrush	0 1 2 3 4 5 6
50) Frequent urinary infection/cystitis	0 1 2 3 4 5 6
51) Vaginal discharge/irritation	0 1 2 3 4 5 6
52) Painful periods	0 1 2 3 4 5 6
53) Breast tenderness or lumps	0 1 2 3 4 5 6
54) Sores/irritation or penis	0 1 2 3 4 5 6
55) Burning or itching of groin/scrotum	0 1 2 3 4 5 6
56) Inability to maintain an erection	0 1 2 3 4 5 6
57) Bronchial asthma	0 1 2 3 4 5 6
58) Hay-fever	0 1 2 3 4 5 6
59) Tightness in chest	0 1 2 3 4 5 6
60) Shortness of breath	0 1 2 3 4 5 6
61) Affected by tobacco smoke, chemicals	0 1 2 3 4 5 6
62) Heart palpitations	0 1 2 3 4 5 6
63) Quick-tempered	0 1 2 3 4 5 6
64) Poor memory/concentration	0 1 2 3 4 5 6
65) Lack of interest in life	0 1 2 3 4 5 6

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|-----------------------------------|---------------|
| 66) Don't feel rested after sleep | 0 1 2 3 4 5 6 |
| 67) Constant thirst | 0 1 2 3 4 5 6 |
| 68) Sleeplessness | 0 1 2 3 4 5 6 |
| 69) Nausea/queasiness | 0 1 2 3 4 5 6 |
| 70) Fluid retention | 0 1 2 3 4 5 6 |
| 71) Blackouts/fits | 0 1 2 3 4 5 6 |
| 72) Dizzy spells/vertigo | 0 1 2 3 4 5 6 |
| 73) Vivid dreams/nightmares | 0 1 2 3 4 5 6 |
| 74) Other (please state) | 0 1 2 3 4 5 6 |

G.P:

Add:

No report, unless requested