Cupping & Complementary Medicine Clinic

DNA FORMULATED REMEDIES
Consent, Medical, Consultation & Case Study Form

New Patient Form

Private & Confidential

Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. Print all information and indicate areas of confusion with a question mark. Thank you.

Date: ……

1: Personal Details

Title & Name					
Address					
Tel		**Mob**			
Email					
Date of Birth		**Age**		**Gender**	Male/Female

2: Medical History

What is your Medical History?
Details

3: Current medical health concern

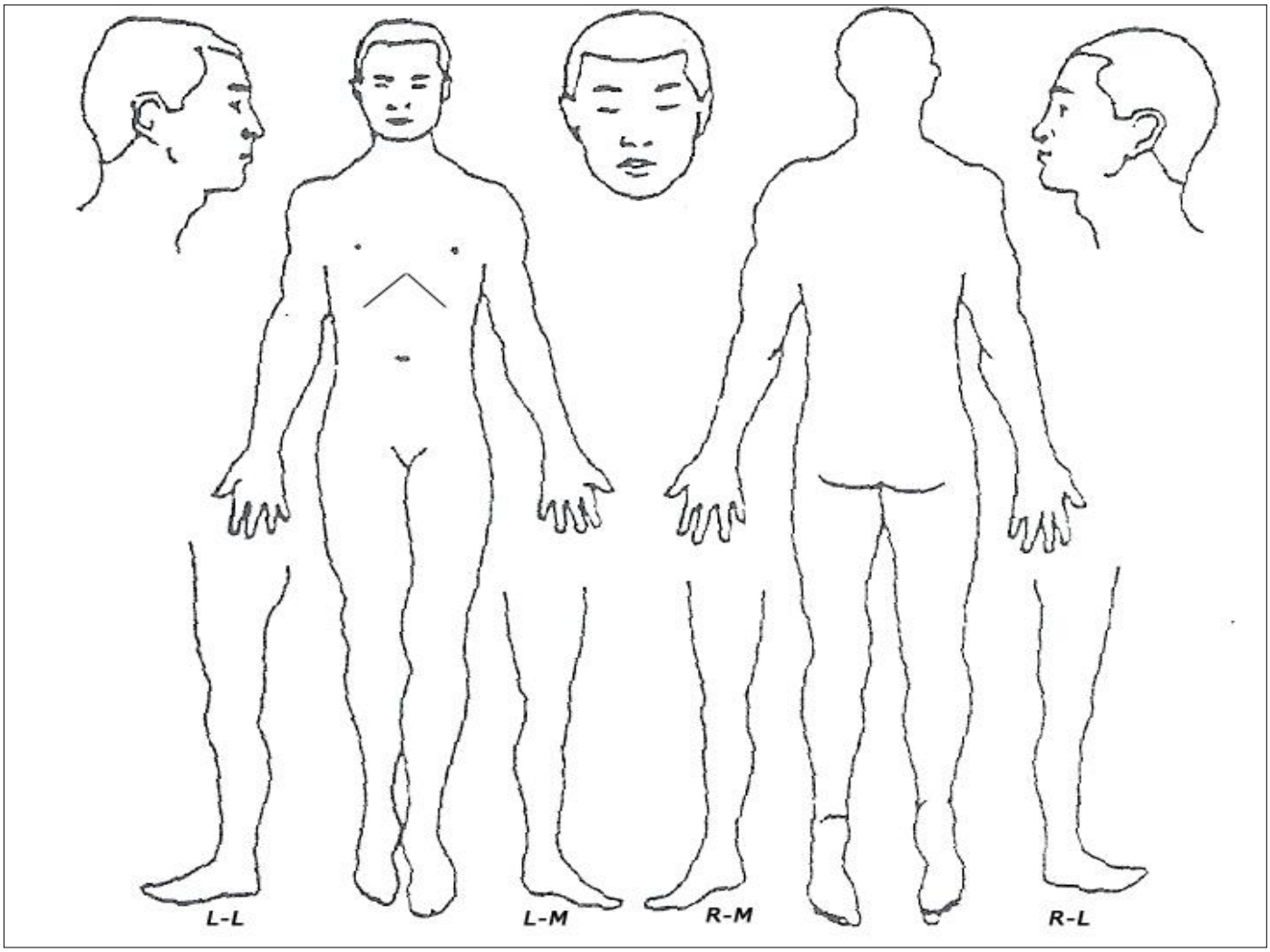
Details

4: Current Medication & Supplements being taken

Details

5: Problem Areas

Please mark the location of your pain on these figures



6: Medical Check List

Please tick symptoms you currently have or have had in the past

General		[ ]	Tremors
[ ]	AIDS/HIV positive/ ARC (aids related complex)	[ ]	Stutter
[ ]	Allergies / hay fever	[ ]	Sweat easily, even with little exertion
[ ]	Anemia	[ ]	Swollen hands / feet
[ ]	Ankle swelling	[ ]	Weakness
[ ]	Arthritis	[ ]	Weight Change
[ ]	Back Pain	[ ]	Womens problems
[ ]	Blue extremities	[ ]	Varicose veins
[ ]	Blood Pressure [ ] High [ ] Low		
[ ]	Bone Fracture		
[ ]	Bruise easily	**Skin**	
[ ]	Bruxism temporomandibular joint problems (TMJ) / grinding teeth	[ ]	Acne
[ ]	Cancer	[ ]	Burning
[ ]	Catch colds and flu easily	[ ]	Changing moles or lumps (cysts/tumors)
[ ]	Chills	[ ]	Dry
[ ]	Chills alternating with fever	[ ]	Eczema /hives
[ ]	Diabetes	[ ]	Itchy
[ ]	Dislocated Joints	[ ]	Moist/Clammy
[ ]	Fatigue	[ ]	Skin Rashes
[ ]	Fever	[ ]	Hair loss/thinning
[ ]	Feverish in the afternoon or hot flushes	[ ]	Dry Scalp/Dandruff
[ ]	General feeling of heaviness in the body		
[ ]	Goiter	**Ears**	
[ ]	Hair Changes/Hair loss	[ ]	Discharge
[ ]	Heat / Cold Intolerance	[ ]	Hearing trouble
[ ]	Heat sensations in the hands, feet, chest	[ ]	Pain
[ ]	Heart Problems	[ ]	Ringing in ears
[ ]	Kidney Trouble		
[ ]	Liver Problems		
[ ]	Mens problems		
[ ]	Multiple Sclerosis	**Eyes**	
[ ]	Muscle spasms, twitching, cramping	[ ]	Blood shot eyes / Dry eyes
[ ]	Nail Changes	[ ]	Blurred vision
[ ]	Neck shoulder tension / pain	[ ]	Discharge
[ ]	Night Sweats	[ ]	Pain
[ ]	Numbness of hands and feet	[ ]	See floating black spots in the eyes
[ ]	One-sided pain / discomfort	[ ]	Vision Trouble
[ ]	Pain in your arms, legs or joints (knees, hips etc)		
[ ]	Pain / tenderness in the ribs	**Head**	
[ ]	Polio	[ ]	Dizziness
[ ]	Prolapsed organs (previously diagnosed)	[ ]	Epilepsy
[ ]	Rheumatic Fever	[ ]	Fainting spells
[ ]	Sciatica	[ ]	Headaches – location:
[ ]	Serious Injury	[ ]	Memory problems
[ ]	Seizure / convulsions	[ ]	Sinus congestion / pressure
[ ]	Slow healing wounds		
[ ]	Spinal Disc Disease	**Nose**	
[ ]	Stiff neck / shoulders	[ ]	Absence of smell
[ ]	Thyroid Trouble	[ ]	Bleeding
[ ]	Tuberculosis	[ ]	Pain

Medical Check List- continued

Mouth & Throat		**Heart**	
[ ]	Absence of taste	[ ]	Chest pain
[ ]	Bad breath (foul/putrid)	[ ]	Chest pain radiating to shoulder
[ ]	Bitter taste in the mouth	[ ]	Heart murmur
[ ]	Bleeding, swollen painful gums	[ ]	Heart Trouble
[ ]	Dry mouth, throat, nose or skin	[ ]	High Blood Pressure
[ ]	Frequent sore throats	[ ]	Low Blood Pressure
[ ]	Mouth sores (canker sores)	[ ]	Palpitations
[ ]	Sores on the tip of tongue	[ ]	Tight feeling in the chest
Stomach& Intestines		**Psychological**	
[ ]	Abdominal bloating or gas after eating	[ ]	Anxiety / nervousness / fidgety /restless
[ ]	Low Appetite	[ ]	Anger easily
[ ]	Excess Appetite	[ ]	Depression
[ ]	Burning sensation after eating	[ ]	Memory loss or impairment
[ ]	Constipation	[ ]	Mental sluggishness / forgetfulness / exhaustion
[ ]	Diarrhoea	[ ]	Mental/Emotional Difficulty
[ ]	Diarrhoea alternating with constipation	[ ]	Mood swings
[ ]	Feeling tired after eating	[ ]	Phobias
[ ]	Heartburn / belching		
[ ]	Nausea, gas or indigestion	**Allergies / Sensitivities**	
[ ]	Stomach pain	[ ]	Animal hair / dander /Dust/ molds /weeds/ pollen
[ ]	Stomach ulcer	[ ]	Chemicals:
[ ]	Vomiting	[ ]	Food:
		[ ]	Medication:
Lungs		[ ]	Others:
[ ]	Asthma		
[ ]	Cough		
[ ]	Difficult breathing		
[ ]	Shortness of breath (□ inhale or □ exhale)		
[ ]	Wheezing		

Since your symptoms began, have you noticed a change in			
Bowel Function		**Bladder Function**	
[ ]	Normal	[ ]	Normal color (pale yellow)
[ ]	Constipation	[ ]	Clear
[ ]	Diarrhoea/loose stools	[ ]	Dark yellow
[ ]	Bloody stools	[ ]	Reddish
[ ]	Black stools	[ ]	Cloudy
[ ]	White/light color stools	[ ]	Has odour
[ ]	Mucus in stools	[ ]	Burning
[ ]	Hemorrhoids	[ ]	Painful
[ ]	Unusually foul smelling stools	[ ]	Difficult/weak
[ ]	Colon problems	[ ]	Urgent /Inability to hold urine
[ ]	Other:	[ ]	Frequent Urination
		[ ]	Other

7: Women Patients

Please tick the appropriate responses.

Are you pregnant?		[ ]	Low back pain
[ ]	Yes	[ ]	Painful periods
[ ]	No	[ ]	Blood clots
[ ]	Maybe	[ ]	Irregular cycle
		[ ]	Breast lumps / tenderness
[ ]	Are you currently menstruating ?	[ ]	Difficulty conceiving
[ ]	Have you had any miscarriages ?	[ ]	Water retention
[ ]	Have you had repeated cases of miscarriages?	[ ]	Missed periods
		[ ]	Food cravings:
Menstrual Cycle – how many days?		[ ]	Fatigue when on periods
		[ ]	Vaginal Discharge
Menstrual flow is:		[ ]	Nipple Discharge
[ ]	Normal	[ ]	Vaginal Itching
[ ]	Heavy	[ ]	Endometriosis (uterus lining problems/growth)
[ ]	Light/scanty	[ ]	Fibroids (non-cancerous growths in the womb)
		[ ]	Ovarian cysts / Polycystic ovaries
Are you on birth control?		[ ]	Urinary Tract Infections
[ ]	Yes	[ ]	Polyps
[ ]	No	[ ]	Pelvic inflammatory disease
	if yes, How long?	[ ]	Headaches when on periods
[ ]	Menopausal symptoms	Operations:	
[ ]	Premenopausal symptoms	[ ]	Cervix
[ ]	PMS	[ ]	Uterus
[ ]	Bleeding between cycles	[ ]	Ovaries

Details of other problems

8: Men Patients

Details of Men's problems

9: Life Style/ Habits

	Yes	No	Daily Amount		Yes	No	Daily Amount
Coffee/Black tea				**Tobacco**			
Recreational Drugs				**Alcohol**			
Water intake				**Soda/Coke**			

Exercise Routine (eg: how many time per week, Intensity or time spent)

10: Do you suffer from any of the following conditions?

[ ]	Have you had a Heart By-Pass?
[ ]	Do you have a pace maker?
[ ]	Do you have any device placed on/near the heart eg, stent, valves
[ ]	Have you had any other major heart operation?
[ ]	Do you have a tendency to faint or have blackouts or epilepsy ?
[ ]	Do you have a Psychological case of Insanity or Rage

Do you have Cancer?	[ ] Yes	[ ] No
If so, where and what type		

Do you have any allergies e.g. penicillin, lactose, foods etc…	[ ] Yes	[ ] No
If so, what from		

11: Authorisation/Consent

I, the undersigned, do hereby confirm that I am the above-mentioned patient, I have read and understand the content of this form and also the before and after treatment plan.

I hereby accept full and complete responsibility for my health and all conditions thereof related. I understand and acknowledge that Health Elements, or any therapist or representative thereof make any claims, medical or otherwise, regarding the use of these services or any other products to cure or treat any disease or injury.

I understand the remedies are designed to be a health aid and is no way to take place of a doctor's care when it is indicated. Information exchanged during any session is educational in nature and should be used at your own discretion. All Client information is held in strict confidence.

I give permission to the Therapist to administer the remedies. I am fully responsible for this decision and do not hold the Practitioner liable for any injuries or other outcomes. The undersigned hereby forever release, discharge, acquit, and hold harmless from any and all claims, actions, suits, demands, liabilities, judgments and proceedings particularly related to or arriving from the personal demonstration of any of the above mentioned by Health Elements, or any representative thereof.

CANCELLATION POLICY

I understand that unless I call or cancel my appointment/treatment within the 24 hour notice. I will be charged in full for the missed appointment/treatment.

I have read, understand and agree to all of the above.

I confirm that the information on this form is correct and accurate and no material information has been omitted. If I become aware that any of the information in this form is incorrect or out of date, I will inform my Complementary Medicine Practitioners immediately.

If you are under 18 years of age, please have your parent or legal guardian sign below.

I have read and agree to the terms of the preceding paragraphs. All the information is true to the best of my knowledge

Signature:_____ Date: _____

Additional Notes/ Information Update