

Sally Horrobin, ND
Get Natural Wellness Clinic, 11 Periton Lane
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Client Registration Form

Please complete the following questionnaire as thoroughly as possible to help Sally understand who you are on a physical, emotional, mental and spiritual level. This will become a part of your confidential records and will not be released unless you have authorized her to do so.

Surname: _____ First name: _____
Date of birth: _____ Age: _____ Gender(sex): _____ *Email: _____
Address: _____ Postcode _____
Home phone: _____ May I leave a confidential message at this number? Yes No
Work/mobile phone: _____ May I leave a confidential message at this number? Yes No
Emergency contact: _____ Phone: _____ Relation: _____
Are you: ___ Single ___ Married ___ Partnered ___ Separated ___ Divorced ___ Widowed
Do you have children? Y / N (names and ages): _____
Your occupation: _____ Your education: _____
How did you hear about us? _____

*Email will only be used to contact you to process your orders, appointments or treatment with Sally. It will not be shared with anyone.

Present Health Concerns (in order of importance):

Duration:

1 _____
2 _____
3 _____

Please describe what you think is the cause of your health conditions (please use separate sheet if needed):

Please list any vitamins/herbs/supplements that you are taking:

Name	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please list any prescription drugs or over-the-counter medicines that you are taking:

Name	Reason for taking	Dose/day	For how long	Who prescribed
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies: (Please circle any which are life-threatening)
_(drugs, food, metal, environmental (grass/pollen, etc.)

Are you sensitive to chemical smells?_____ Have you had repeated exposure to any chemicals, fumes, dust? (if so, please specify)_____

Medical History:

Primary Care Doctor/Provider:_____ Date last seen:_____

Reason for seeing:_____

Doctor's Address:_____

Doctor's phone:_____

Date of your last physical exam:_____ Results:_____

Date of last blood work:_____ Results:_____

Date of last PAP/pelvic exam:_____ Results:_____

Date of last mammogram:_____ Results:_____

Date of last prostate exam:_____ Results:_____

When was your last menstrual period?_____ Are you pregnant?_____ How far along?_____

Are you sexually active? (circle one) Yes / No If yes, is it with (circle one): male female both

Do you or your partner(s) use any form of contraception? Yes / No If so, what type(s)?_____

Family History: Please designate which family members have had the following health conditions.
M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Allergies	Diabetes	Mood/Mental disorder
Alcoholism	Cancer	Neurological disease
Anemia	Endometriosis	Obesity
Arthritis-Rheumatoid	Heart Disease	Skin problems
Arthritis-Osteo	High Blood Pressure	Stroke
Autoimmune disease	High Cholesterol	Thyroid disease
Depression	Kidney disease	Tuberculosis

Exercise: (Please specify what type of exercise, duration, and frequency per week)

Sleep Habits:

How many hours do you sleep per night?_____ Do you wake refreshed?_____

Do you have problems: falling asleep staying asleep waking up in the morning

Energy Level: (Please circle your average daily energy level)
(lowest energy) 1 2 3 4 5 6 7 8 9 10 (highest energy)

Stress Level: (Please circle your average daily stress level)
(lowest stress) 1 2 3 4 5 6 7 8 9 10 (highest stress) How do you cope with stress? _____

Review of Systems (please circle any symptoms you have experience in the last 6 months)

General	Skin/EENT	Heart/Lung	Gastrointestinal	Endocrine
Weight change	Itching	High blood pressure	Poor appetite	Diabetes
Fever/chills	Rashes	Low blood pressure	Heartburn/GERD	Hypothyroid
Weakness	Hives	Heart palpitations	Constipation	Hyperthyroid
Fatigue	Eczema	Heart attack	Diarrhea	Goiter
Night sweats	Vision changes	Heart disease	Gas/bloating	Hypoglycemia
Dizziness	Dental problems	Shortness of breath	Nausea/vomiting	Hot flashes
Memory loss	Ringing in ears	Wheezing	Hemorrhoids	Increase thirst
Mood changes	Earaches	Chronic coughing	Ulcers	High appetite
Sleep issues	Sinus infections	Stroke	Blood in stool	Hair loss
Anxiety/Depression	Sore throats	Swollen ankles	Anal discomfort	Weight gain
Genitourinary	Musculoskeletal	Female Only	Male Only	Other
Low back pain	Neck pain	PMS	Breast lumps	Anemia
Painful urination	Low back pain	Breast lumps	Erection difficulty	Osteoporosis
Blood in urine	Hip pain	Heavy menses	Pain in testicles	Cancer
Frequent urination	Foot pain	Hot flashes	Penis discharge	Fibromyalgia
No bladder control	Shoulder pain	Painful intercourse	Sores on penis	Crohn's dz
Nighttime urination	Arm pain	Hysterectomy	Infertility	Colitis
Bladder infections	Arthritis	Fibroids	Low libido	STDs
Kidney infections	Tendonitis	Abnormal pap	Swelling of testes	ADD/ADHD
Kidney stones	Strain/sprain	Low libido	Hernia	Mood disorder
Renal failure	Spasm/Swelling	Vaginal infections		Eating disorder

Diet History:

How many meals do you eat per day? (please circle) One Two Three Four or more

How much water do you drink per day? (please circle) None .5-1.5 pints 1.5-3.5 pints 3.5 pints or more

Coffee: (Number of cups per day)_____ Fizzy drinks (Number of cans per day)_____

Tea: (Specify type and number of cups per day)_____

Please specify a typical daily diet:

<u>Meal</u>	<u>Time</u>	<u>Food and Amount</u>	<u>Beverages</u>
Breakfast			
Snack			
Lunch			
Snack			
Dinner			

Please list any food allergies that you have and the type (anaphylactic or food intolerances)

Personal Habits: (Please specify current or past usage of these substances and how much)

Tobacco:_____

Alcohol:_____

Caffeine:_____

Recreational drugs:_____

Digestive Health:

Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (please circle or specify): _____

Bowel movement frequency:(how often)_____ Consistency:(hard, soft, watery, normal)_____

Do you experience constipation or diarrhea? (please circle or specify)_____

Do you have blood or mucus in the stool? (please circle or specify)_____

Eliminations:

Do you experience pain with urination, incontinence, other urinary symptoms? (please circle or specify)? _____

Urination frequency: (how often per 24 hour period) _____

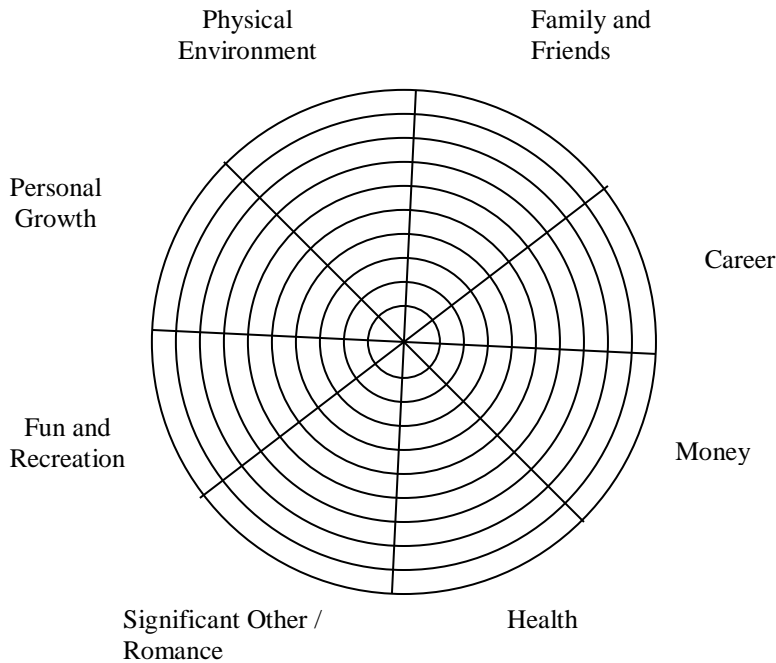
Color of urine: (dark yellow, light yellow, green, colorless) _____ Blood in urine? _____

Menses: (female)

Are your menses regular (average every 28 days)? _____

Do you experience cramps, excessive menstrual flow, hot flashes, fibrocystic breasts, mood issues, bloating and swelling, bleeding in between menstrual cycles, other PMS issues? (please circle or specify) _____

Life Balance: Wellness is a balance of many factors in life. Using the circle, please shade your level of satisfaction in each area. For example, if you are 60% satisfied with your career, shade the first 6 levels in the career slice. Do the same for each area starting from the center point radiating out.



Context of Care Review

Successful health care and preventative medicine are only possible when I have a complete understanding of my client physically, mentally and emotionally. Your response to the following questions will assist my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1. Why did you choose to come to this clinic?

2. What do you know about my approach?

3. What three expectations do you have from this visit?

- a.

- b.

- c.

4. What long term expectations do you have from working with me?

5. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0-10, 10 being 100% committed.)

1 2 3 4 5 6 7 8 9 10

6. What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

7. What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?
