

CASE HISTORY

Please include approximate dates wherever possible.

Return to:						
Full Name						
Address						
Telelephone Mobile						
Email address						
Date and place of birth:						
Age Occupation						
Marital status Children						
Introduced by						
Symptoms						
Date of onset						
Sudden/Gradual						
Medical diagnosis – please include dates						
Treatment you have had for the present complaint – please include dates						
Complaint made worse by						
Complaint eased by						

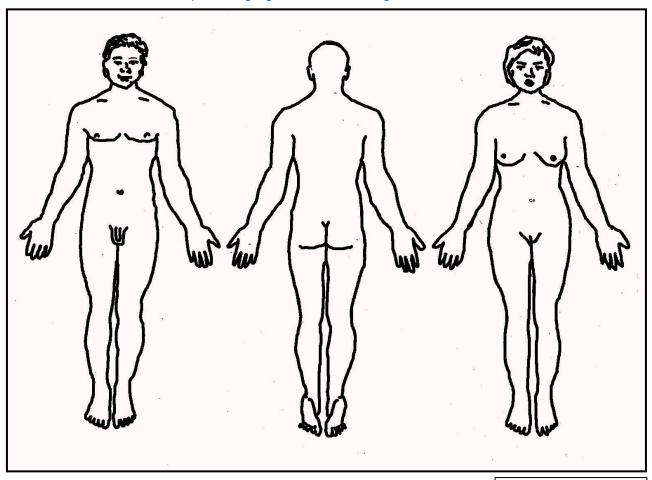
Falls and accidents – including	dates	
Serious illnesses – including d	ates	
Surgery - please include appr	oximate dates	
Previous natural therapeutic tr	eatments:	
Have you had any of the follow	ring? If so, list and give app	proximate dates
X-Rays		
Inoculations		
Last medical examination date		
Blood transfusions, number of		J
Have you ever suffered from:		
Asthma	Migraine	
Bronchitis	Mumps	
Chicken pox	Pneumonia	
Cystitis/urethritis	Rheumatic fever	
German measles	Scarlet fever	
Jaundice	Tuberculosis	
Malaria	Venereal disease	
Measles	Whooping cough	

Do you now suffer from:	
Any allergies	Varicose veins
Insomnia	Constipation
Lack/excess of appeting	te Diarrhea
If so name the remedy used	
Have you ever taken any of t	he following? If so, specify the actual drug if possible:
Antibiotics	Tranquillizers
Quinine	Sleeping tablets
Anti-malarial drugs	Pep pills
Steroids	Hormone replacements
Tonics	Cortisone
Barbiturates	Social drugs
Vitamins	Contraceptive Pill
What medicines (if any) are y	you taking now?
()	
Have any of your relatives su	
Asthma	Kidney problems
Cancer	Neurosis
Diabetes	Mental trouble
Excema	Rheumatic Fever
Epilepsy	Tuberculosis
Heart trouble	Arthritis
Any general comments you f	eel may be important and relevant to your health:
Height	Weight
3	

Blood Pressure: High/Low							
Temperament and personality characteristics:							
Recreational or other interests:							
Daily intake of: Alcoho	ol	Cigarette	s/tobacco				
Comments on your diet, including daily fluid intake (other than alcohol):							
Religion, Spiritual Faith or Practise/ Philosophy of Life:							

Please use the diagrams to indicate and/or describe any areas of pain or discomfort:

Use 'Insert': 'Illustrations' : 'Shapes' to highlight areas on the diagrams



Req		
Sent		
Rec		