HEALTH
SOLUTIONS (NATURAL)

# CASE TAKING FORM

**First names:**

**Surname :**

**Address:**

**Postcode:**

**mobile number:**

**e-mail address:**

**Date of Birth:**

**Current Age:**

**Where were you born(country) and where were you brought up(country)?**

Please tick your preference:

☐ Consultation in person (1.5 hour)

☐ Telephone consultation (if condition allows)

☐ Skype consultation (if condition allows)

Please explain and list health complaints :

## History from 0 to 18 age old

**Details of your Birth:**

Was your birth induced/forceps used/Caesarean/premature/jaundice/toxaemia/normal vaginal

Other complications your mother had during pregnancy?

Were you breast-fed/how long?



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Any hospitalization during early childhood ?(explain)

Anything special happen during that period?

Give dates and any reaction to all vaccinations (if known):

## General history

**Do you have a history of: (please circle)**

Give the age of onset and/or frequency of the complaint. details of treatment (medication, alternative treatment, surgery).

| | Age/ frequency | Treatment |
|---|---|---|
| Acne | | |
| Allergies | | |
| Anxiety | | |
| Alcohol (how often) | | |
| Arthritis | | |
| Asthma | | |
| Boils/abscesses | | |
| Bowel disorders | | |
| Bronchitis | | |
| Cancer (name type) | | |
| Candida | | |
| Chickenpox | | |
| Circulatory/heart | | |
| Celiac | | |
| Colds/'flu(how often) | | |
| Colitis | | |
| Constipation | | |



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Crohn's

Cystitis

Depression

Dermatitis

Diabetes

Diarrhoea

Digestive problems

Diphtheria

Diverticulitis

Dysentery

Eating disorders

Eczema

Epilepsy

Gall bladder

German measles

Glandular fever

Haemorrhoids

Hay fever

Headaches

Hernia

Herpes

Hepatitis

Insomnia

Jaundice

Kidney infection/disease

Malaria

Measles

Meningitis

Migraine



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Mumps

Peptic ulcer

Phobias

Pleurisy

Pneumonia

Psoriasis

Rheumatic fever

Sinusitis

Smoking

Thrombosis/stroke

Thyroid (under/over-active)

Tonsillitis

Tuberculosis

Whooping cough

**Any other illnesses/operations:**

**Is there a family history of any illness -**

Relationship (mother/father/sibling/grand-parent etc.)



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## Female section only

Details of menstruation:

(Year of onset/menopause, irregularities, length of cycle/flow etc.)

Have you taken the contraceptive pill or been prescribed any other type of hormonal treatment: (Give details of medication, length of time prescribed, dates/year, side-effects etc.)

**Details of pregnancies and births:** Was birth normal vaginal/induced/forceps used/ Caesarean/ premature/ jaundice/toxaemia or other complications during pregnancy?

**Have you experienced any fertility problems with the following and state the date/year and any treatment given:**

| | year | Treatment |
|---|---|---|
| Miscarriages | | |
| Terminations | | |
| Complications | | |
| Infertility | | |
| Surgeries | | |



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**Current diet:**

| | |
|---|---|
| How many meals do you have a day? | |
| How many cups of tea/coffee? | |
| Do you have food cravings (give details, type of, frequency, time of day/month)? | |
| Do you have food allergies (give details and symptoms)? | |
| Do you have food intolerances or digestive difficulties (give details and symptoms)? | |
| What is your daily intake of alcohol? | |
| What is your daily fluid intake (other than alcohol)? | |
| Do you experience a lack/excess of appetite? | |
| Give a detailed description of a normal daily eating plan for breakfast, lunch and evening meal. Include all foods, drinks, snacks etc. | Breakfast:<br><br>Lunch:<br><br>Evening meal:<br><br>Snacks: |



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**Examination:**

Your height and weight

Temperature

Do you tend to feel the cold easily?

Do your hands and feet get cold?

Do you feel uncomfortable with heat?

Do you suffer night sweats/day sweats/hot flushes?

Pulse

Blood pressure

Your Tongue:

Please can you fill in the table below by either ticking the appropriate lines or saying “Yes”

| General body of colour | | Texture | | Coating | | Cracks | |
|---|---|---|---|---|---|---|---|
| pink | | Dry | | thin | | none | |
| red | | Wet | | thick | | transverse | |
| purple | | normal | | yellow | | vertical | |
| pale | | | | cream | | mid-line | |
| dark | | | | white | | mid-line extending to tip | |
| | | | | Thicker at base | | Teeth markings at edges | |
| | | | | | | Quiver when extended | |
| Do you have any areas on the tongue that are red - if so where? | | | | | | | |



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**Nails**

Are any of your fingernails ridged? Are they brittle and/or do they break easily?

Do you have any white marks on the nails?

**Skin**

Is your skin oily/dry/cracks easily (ears, lips)?

**Stress**

List any current or on-going stress factors:

Vaccinations (last 5 years) any reaction to (if known):

State your blood group (if known):

Signature:

Date:



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