Holistic Integrated Patient History Sheet

This form has been created by Drs Martin & Sue Allbright for a holistic and integrated approach to your health and some of the questions will appear quite different and unique to the usual ones. Please answer as much of the following as you can. It is a totally confidential paper record kept in your medical notes and it will not be stored in any electronic version.

SURNAME .... INITIALS.......................................

CALLED [the name you prefer to be called]..

DATE OF BIRTH ....AGE................. SEX Male / Female

ADDRESS...

TOWN/CITY..POSTCODE...

TELEPHONE CONTACT..

NAME & ADDRESS OF YOUR GP..

OCCUPATION..

STATUS Single / Co-habiting / Married / Separated / Widowed

OCCUPATION OF PARTNER...

CHILDREN (First names & ages)..

NATURE OF MAIN PROBLEM..

DURATION OF PROBLEM - Days / Weeks / Months / Years (please circle the relevant)

ANY OTHER PROBLEMS?...
....

OPERATIONS [with year or age at surgery] MEDICAL PROBLEMS [with year or age at diagnosis]

OPERATIONS	MEDICAL PROBLEMS
e.g. TONSILLECTOMY ....Age9......................	e.g. ANGINA ....1990..
....	....
....	....
....	....
....	....

DO YOU HAVE ANY OF THE FOLLOWING ? [please circle the relevant conditions]
Asthma / Diabetes / Epilepsy / High Blood Pressure / Heart Disease / Disease of the Heart Valves / Pacemaker

FAMILY HISTORY *eg FATHER Heart Attack age 65*
....
....
....
....
....
....
....

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Sleep.

Bed is a place for Sleep. Quality sleep is important for getting better. Children only lie awake at night if they are sick, in pain, worried or frightened. Details about your sleep tells us important information about your state of health.

What time do you generally go to bed?..
Do you fall asleep straight away?..
If not what are you doing? (Reading?) ....
If you did not do what you usually do would you toss and turn? ....
Do you take anything to help you sleep? ....
How many hours do you sleep for? ....
If you wake in the night, what time? ....
what wakes you? ....
how quickly do you go back to sleep? ....
Do you wake several times in the night? ....
What would you say is the quality of your sleep? ....
What time do you wake up? ....
Does the alarm wake you? ....
Do you get up straight away? ....
Do you feel ready to get going? ....
Do you catnap during the day?.......... If so at what time and for how long?...
Anything else you want to share about you sleep?...
....
....

Dreams.

In Traditional Chinese Medicine we DO NOT INTERPRET dreams as in some forms of psychotherapy. However, some dreams (if persistently repetitive or vivid or even a nightmare dream) may be significant in the aspects of oriental diagnosis.

Do you dream?...
Do you have any recurring dreams/nightmares? ....
Briefly describe the theme ....
....
....

Circadian (Day Night or Seasonal) Rhythms.

Is there a particular time of the day or evening when you feel your energy drops? ....
If so what time does it happen and for how long?..
Is there a particular time of the year that you feel worse in?...
If so when is it and what happens to you?..

What goes into you?

(Appetite, Diet, Eating Habits, Fluids, Alcohol, Smoking, Medicines, Non prescribed drugs.)

Appetite, Diet, Eating Habits.

People generally do not notice the amount they eat until they take it through a step by step analysis of their daily intake. Lets go back to yesterday.

What did you have for breakfast?...
What might you have anything between breakfast and lunch? ....
What do you have for lunch?...
Do you have anything between lunch and dinner?..
What do you have in the evening?..
After dinner, anything else before going to bed?..
Your preferences or dislikes in taste.
Do you like hot food?..
Do you like cold food?...

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Do you like burnt or bitter things like coffee or burnt toast or bitter chocolate?.......................................
Do you enjoy sweet foods or sweet treats? ....
Do you eat foods that really satisfy you? ....
Do you feel hungry very soon after a meal? ....
Do you eat when you are not hungry? ....
Do you worry about where your next meal is coming from? ....
Do you like pungent spicy foods? ....
Do you like to add salt to your food or like salty food? ....
Do you enjoy, sour, acid or vinegary foods? ....
Is food and cooking and entertaining people with food is important to you? ....
Are you not bothered about food? ....

Fluid Intake.

Drinking the right amount of fluid is important for our lymphatic and fluid-processing systems. Too little fluid or too much fluid has consequences on our health.
When you wake up what do you drink first thing?............................and how much?.............................
What fluids do you drink at breakfast?..and how much?.............................
Between breakfast and lunch what do you drink?............................and how much?.............................
What fluids do you drink at lunch?..and how much?.............................
Between lunch and dinner what do you drink?................................and how much?.............................
In the evening what might you drink?...and how much? ....

Alcohol..

ALCOHOL [upw = units per week; 1 unit = ½ a pint]
UPW.. What sort of alcohol do you like to drink?..............................
When do you drink alcohol? In the day................................In the week...
Why do you drink alcohol? (circle the ones that are right for you)
To relax when come home, loneliness, comfort, boredom, escape from responsibility, worry, frustration, to ease fear, pain of loss, grief, despair, lack of love, bitterness, resentment, Something else
....

Smoking.

Are you a NON-SMOKER or
EX-SMOKER ....[years stopped] or
SMOKER ....[cigarettes per day]
What is your attitude / opinion towards people who smoke ....

Prescription Medicines.

Do you take any prescribed drugs?
eg ASPIRIN 75mg every morning
....
....
....
....
....
....
....

Non Prescribed drugs.

Do you take any non-prescribed drugs? Yes / No. If yes what sort...
Have you taken non-prescribed drugs in the past? Yes / No. If yes what sort..
and how long ago ....
What is your opinion / attitude to the use of non prescribed drugs?...
....

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Elimination Patterns and Natural Rhythms.

(Bowels, Menstrual Cycle, Waterworks, & Perspiration.)

Bowels.

Do your bowels open regularly every day?..
At what time?..
If you do not have a regular pattern, please describe what pattern(s) you have ....
....
....
....
Do you use anything to help or support your bowel function?.............If yes what do you use?................
....
....

Menstrual Cycle.

How old were you when your periods started?..

If relevant - menstruation pattern, if now in menopause please move to relevant section below.

How often do your periods recur?...
Describe the evenness of flow and loss of blood..
....
....
Do you experience any discomfort and or pain with menstruation...
If so please describe it (Type of pain, front or back, middle or to the sides) ....
....
....
....

Menopause.

Are you in the transition phase of the menopause? .... How is the transition going for you?...
....
If you are experiencing Hot Flushes, describe their nature, (eg all over, or from chest upwards, or just head only, only at night, or at any time of the day?)...
....
....

Perspiration.

Do you perspire normally, excessively or hardly at all?...
If so which part of your body perspires excessively?...
Is it with or without exercise?..

Do you perspire when you are nervous?.......................................If so which part of your body perspires excessively?...

Waterworks.

How many times a day do you urinate?..
Do you need to rush to the toilet?...
Do you leak when you cough, or laugh or sneeze?...
Do you have to get up at night to urinate?........................... If so how many times?...............................

Men.

Do you have to tighten your tummy to start the urine flow?..
Do you have to stand there and wait for the urine to emerge?..
When it flows does it just dribble out?...

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