www.healthenergiser.co.uk

Health Energiser

FB @healthenergiser / 07544 813770

Name:
Date of birth:
Address:
Contact no:
E-mail
GP Name and address:

DATE

_____
_____
_____
_____
_____

Chief Complaint

What is your main problem?

Where is the Pain/Symptoms?

When is it Better or Worse?

How long have you had it? And was there any specific cause?

Have you been involved in accident or fall?

Have you seen anyone else about the problem? Have you spoken to your GP?

Have you had any x-rays or other tests? If so, please specify:

Is there any family history of similar problems?

Do you regularly undertake any sport or strenuous activities?

Do you smoke?

What I syour average weekly alcohol consumption?

Do you have any particular goals from receiving treatment (ie, playing sports, walking to shops, picking up grandchildren etc)

Medication

Please list any medication you are taking:

General Health History

It is very important for the practitioner to gain prior knowledge of their patient before any treatment is given. Please specify if you have now or have had any of the symptoms listed below:

Allergy, Convulsions, Dizziness, Fainting, Fatigue, Fever, Headache, Migraine, Loss of sleep, Loss of weight, Neuralgia, Numbness, pain in arms/legs, Sweats, Wheezing

Please specify (state or underline)

Muscle & joint symptoms such as: Jaw joint trouble, stiff neck, pain between shoulders, shoulder/elbow/wrist trouble, backache, spinal curvature, painful tailbone, hernia, hip/knee/ankle joint problems, foot pain, fractures, swollen joint, tremors

Ear, nose and Throat symptoms such as: Asthma, Deafness, Earache Ear problems, Ear noises, Enlarged glands, enlarged thyroid, eye pain eye problems, hay fever, nose bleeds, sinus infection, tonsilitis

Skin symptoms such as, bruises easily, eczema, hives or allergy, itching, sensitive skin, lesions, varicose veins

Respiratory symptoms such as: chest pain, chronic cough, difficulty breathing, spitting up blood, spitting up phlegm

Cardiovascular Symptoms such as; Aortic Aneurysm, hardening of arteries, high/low blood pressure, pain over the heart, stroke, poor circulation, rapid/slow heart beat, swelling of ankles

Diseases such as AIDS, alcoholism, anaemia, anxiety, appendicitis, arthritis, cancer, depression, diabetes, epilepsy, gastric ulcers, glandular fever, heart disease, hepatisis, osteoporosis, pleurisy, pneumonia, rheumatic fever, shingles or other

Gastrourinary Symptoms such as: blood in urine, discoloration of urine, frequent urination, inabliity to control urine, kidney ifection or stones, painful urination

Gastro intestinal symptoms such as: colitis, colon trouble, colon trouble, constipation, haemorrhoids (piles), diarrhea, difficult digestion, belching or gas, indegestion, excessive hunger/thirst, poor appetite, gall bladder or liver trouble, jaundice, vomiting

Women only symptoms such as: cramps or backache, excessive flow, hot flushes, irregular cycle, lumps in breast, pregnancy(current) menopausal symptoms, painful menstrual periods, previous miscarriage, vaginal discharge

Men only symptoms such as: prostate, erectile dysfunction

Consent

Human Right Act: As Health Professionals we must inform you not only minimal risks associated with your treatment, but also of the very rare and unlikely and low risks of more serious debilitating outcomes. To our knowledge, no cases of preventable measures to avoid risk.

I confirm that I have been informed of the potential risks of treatment and give my consent to assessment and treatment. I understgand that I can refuse treatement any time.

I certify that to the best of my knowledge the information given to my practitioner is correct before writing to your GP

I agree to be responsible for payment of the practitioners fees

I give consent for other practitioners at SNHC to view my initial Assessment Notes/Any relevant information held in my e-files concerning my treatment in accordance with General Data Protection Regulation (GDPR)

I give consent for email and text reminders to be sent and a message to be left on my answerphone

_____

Signature

Covid-19 Screening Questions

Do you or any member of your household/family have a diagnosis of covid-19?

Are you or any member of your household/family waiting for Covid-19 test result?

Do you, in the last 10 days travelled internationally or had contact with someone suspected or confirmed diagnosis of Covid-19 or had contact with a person who has been in RED list country?

Do you have any of the following symptom?

High Temperature or fever

New or Continuous cough

Loss or alternation to tase or smell