**Confidential Consultation Form  
Yolande Herring**  **Telephone:** 0414 547 959 **Email:** info@liveinbalance.net.au

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| **Miss/Mrs/Mr/Ms** | **First Name:**  **Surname:** | | **Date of Birth:** |
| **Address:** | | | |
| **Phone:** | | **Email Address:** | |
| **Occupation:** | | **Religious/Spiritual Beliefs:** | |
| **Do you have Private Health Insurance: (if so, provider name)** | | | |

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| **Who were you referred by / How did you hear about me?** |
| **GP Name and address:** |

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| **Briefly describe any issues or stresses you have/would like to resolve:**  **Would you describe this to be: severe / moderate / mild**  **When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **On a scale of 0-10 what is your stress level (0 being no stress)? /10** |
| **What other forms of therapy have you had for this/these issues and when was your last treatment?** |

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| **Please list any medication you are currently taking:** |
| **Please list any supplements/herbal remedies/vitamins you are currently taking:** |

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| **Please provide details if you have had any of the following ever:**  **Mental health issues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Generalised feelings of anxiety: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Ladies only**  **Menstruation**: Age of onset: \_\_\_\_\_\_\_\_\_\_ PMS Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Regularity - every \_\_\_\_\_\_\_\_\_ days Flow: Heavy □ Medium □ Light □ Clotting □  Pain: Before menstruation □ During menstruation □ Sharp □ Dull □  Post-menopausal □ Age of menopause: \_\_\_\_\_\_\_\_\_\_\_\_ Hysterectomy □ |

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| **Tick all relevant:**  **Digestion**: Reflux □ Bloating □ Burping □ Flatulence □ Constipation □ Diarrhoea □ Nausea □  **Stomach/Intestines**: Ulcers □ Ulcerative Colitis □ Crohn’s disease □ IBS □ Other □ Details: ­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_  **Bowels**: How often do you do stool? \_\_\_\_\_\_\_\_\_\_ Loose □ Blood in stool □ Undigested food in stool □ Other □  **Urination**: Frequent □ At night □ Blood in urine □ Painful urination □ Urine retention □ Incontinence □ |

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| **Please provide details of any ongoing medical conditions, injuries, areas of pain or limited/restricted movement that have not been mentioned on this form yet eg headaches/migraines; skin conditions; issues with heart, eyes, spine or joints, scoliosis, throat, swallowing, speech: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **What is your daily intake of pure water? (Do not include fruit juice/herbal tea/coffee)**  **More than 2 litres 2 litres 1 Litre 500ml Less**  **Do you get thirsty: Yes** □ **No** □  **Briefly describe your diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Do you have any cravings? Please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Do you prefer drinks to be: Hot** □ **Cold** □ **No preference** □  **How often do you exercise? Daily Weekly Occasionally Never**  **What form of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **On a scale of 1-10 what is your energy level (1 being lowest)? /10**  **What time of the day do you feel: most energetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ least energetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Do you sleep well? (falling asleep, staying asleep, etc) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **What time/s of the night do you wake? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **How do you feel first thing in the morning? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Do you usually feel: Hot?** □ **Cold?** □ If so where in your body (eg hands, feet, body, head) and what times of day/night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do you sweat a lot? Yes** □ **No**  □ |

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| **Please list any other concerns/comments regarding your state of health/well being that have not been covered even if you feel they have no relevance to your current condition:** |

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| **Please list 3 outcomes you would like as a result of these sessions?** |

**Please read and sign:**

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| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_confirm that the answers and information I have given are true and correct to my knowledge. I hereby confirm I am willing to proceed with treatment without confirmation from my own GP or consultant.  Signed: Date: |

**Ladies only** (of childbearing age)

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| **Are you or is there a possibility you could be pregnant? Y** □ **N** □ **If yes how advanced?** \_\_\_\_\_\_\_\_ weeks |

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| I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to inform my therapist if I suspect that I am pregnant or if pregnancy is confirmed prior to the beginning of any future sessions.  Signed: Date: |

**Please note: all information supplied on this form and during sessions is strictly confidential.**