

MEMBER QUESTIONNAIRE

Personal Details (please tick or fill in where appropriate)

Name:		
Address:		
<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth:	Age:
Day contact phone:	Night contact phone:	Mobile:
Occupation:		
Email address:		
Referred by:		

Current Concerns

<p style="color: red; margin: 0;">Primary concerns:</p>
<p>Other concerns:</p>

Other Information

I am pregnant <input type="checkbox"/> No <input type="checkbox"/> Yes
I have a communicable disease (HIV, hepatitis, other infectious disease) <input type="checkbox"/> No <input type="checkbox"/> Yes (give details):
I wear a pacemaker or bionic device <input type="checkbox"/> No <input type="checkbox"/> Yes (give details):

Medical History

Previous operations, health problems and accidents (of reasonable concern):

Current Medications

Medication:	Dosage:	Prescribed for:

Known Significant Family Health Conditions

Mother:	Father:	Grandparents:

Continued over...

Please tick or fill in items that are relevant:

Doctor's diagnosis (if any):
List your actual symptoms :
Blood pressure (if known):
Breath (if anyone has told you):
Face appears: <input type="checkbox"/> Pale <input type="checkbox"/> Reddish <input type="checkbox"/> Acne <input type="checkbox"/> Pimples <input type="checkbox"/> Blotchy <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Normal
Condition of hair : <input type="checkbox"/> Good <input type="checkbox"/> Oily <input type="checkbox"/> Dry <input type="checkbox"/> Falling out
Condition of nails : <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Ridges <input type="checkbox"/> White spots
Condition of skin : <input type="checkbox"/> Normal <input type="checkbox"/> Dry <input type="checkbox"/> Pale <input type="checkbox"/> Tanned <input type="checkbox"/> Other (give details):
Bladder habits I empty my bladder (give approximate number): <input type="checkbox"/> times during the day <input type="checkbox"/> times during the night
Bowel habits I empty my bowels (give approximate number): <input type="checkbox"/> times daily, and bowel movements are generally: <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Bloody <input type="checkbox"/> Difficult to pass <input type="checkbox"/> Runny <input type="checkbox"/> Loose <input type="checkbox"/> Firm <input type="checkbox"/> Very firm
Men: When passing urine I notice that it is <input type="checkbox"/> Frequent <input type="checkbox"/> Limited flow <input type="checkbox"/> Painful <input type="checkbox"/> Dripping after
Women: Briefly describe menstrual cycle
I smoke <input type="checkbox"/> cigarettes per day

I drink <u>daily</u> (give approximate number): <input type="checkbox"/> cups of coffee <input type="checkbox"/> cups of tea <input type="checkbox"/> cups of milk <input type="checkbox"/> glasses of water <input type="checkbox"/> soft drinks / cordials <input type="checkbox"/> 'sports drinks' <input type="checkbox"/> glasses of beer <input type="checkbox"/> other alcoholic drinks
I eat <u>daily</u> (give approximate number): <input type="checkbox"/> pieces of fruit <input type="checkbox"/> servings of vegetables
I eat <u>weekly</u> servings of (give approximate number): <input type="checkbox"/> red meat <input type="checkbox"/> chicken / eggs <input type="checkbox"/> fish I like my meat <input type="checkbox"/> Raw / Rare <input type="checkbox"/> Medium <input type="checkbox"/> Well done <input type="checkbox"/> Charred
Sleep habits I usually sleep for about (give approximate number): <input type="checkbox"/> hours per day, and my sleep is generally: <input type="checkbox"/> Regular hours <input type="checkbox"/> Irregular hours <input type="checkbox"/> Sound <input type="checkbox"/> Broken
I have a tendency to feel / act / have : <input type="checkbox"/> Emotional <input type="checkbox"/> Tense <input type="checkbox"/> Withdrawn <input type="checkbox"/> Muscular tension <input type="checkbox"/> Talk quietly <input type="checkbox"/> Talk loudly <input type="checkbox"/> Rush about <input type="checkbox"/> Take it easy <input type="checkbox"/> Other (give details):
I take recreational drugs <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly Please give details):
Exercise: Describe the type and frequency of exercise that you get/undertake
Summarise how you feel <u>now</u> (in a few words), before the program
Signature: Date: