THE PERRYMOUNT
OSTEOPATHY & NATURAL HEALTH CLINIC

Christian Bates Bsc(Hons) Ost. Med. DO ND
Registered Osteopath & Naturopath,
Certified Metabolic Typing Advisor

Name: ..... Date of Birth: .....

Address: .....

..... Postcode: .....

Home No: ..... Mobile: ..... Work No: .....

Email: ..... Occupation: .....

Name of private health cover: ..... Policy No's: ..... Todays Date: .....

Name: .....

How did you hear about the clinic?

- ☐ Yellow pages
- ☐ yell.com website
- ☐ Bright Fm radio
- ☐ Local newspaper
- ☐ BT phone book
- ☐ Lindfield Life
- ☐ Internet/google search
- ☐ Friend, family, current patient
- ☐ Sign outside
- ☐ GP referral
- ☐ Website
- ☐ Dolphin surgery board
- ☐ Other

Do you have any known allergies? ☐ Yes ☐ No

Any unusual childhood illnesses? ☐ Yes ☐ No

Are you on any medication or supplements? ☐ Yes ☐ No

Have you ever taken steroids or antibiotics? ☐ Yes ☐ No

Have you had any operations (in your entire life please)? ☐ Yes ☐ No

Do you have any named conditions / disease? ie diabetes, high blood pressure, cancer etc? ☐ Yes ☐ No

Have you had any X-rays, blood tests or other investigation? ☐ Yes ☐ No

Do you have any problems that run in the family, for example heart disease, high blood pressure, diabetes, cancers or anything else? ☐ Yes ☐ No

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Have you had any accidents eg car / motor cycle, falls, concussions? ☐ Yes ☐ No

Any major emotional traumas? ☐ Yes ☐ No

Dental work? Root canals ☐ Fillings ☐ Silver/mercury, how many? ☐ Braces/bridges etc ☐

I consent to receiving treatment or give permission for my child to receive treatment and also to the information regarding my medical condition being shared with my GP if necessary. I also understand that for osteopathic treatment to be effective and safe I may have to remove some of the top layers of my clothing so that the osteopath can examine me fully. We may also send you occasional newsletter with health information and special offers.

Signature: Date:

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Answer all symptoms as they have been over the last 30 days or since you last filled out this form, which ever was most recent. Simply cross or fill in the appropriate score for each symptom. Use the following scale:

●①②③④ No symptoms at all
⓪●②③④ Suffer occasionally / mild
⓪①●③④ Suffer often / moderate
⓪①②●④ Suffer often / severe
⓪①②③● Suffer frequently / severe

Nasal / sinus

⓪①②③④ Post nasal drip
⓪①②③④ Sinus pain
⓪①②③④ Runny nose
⓪①②③④ Stuffy nose
⓪①②③④ Sneezing

Lungs

⓪①②③④ Congestion
⓪①②③④ Asthma
⓪①②③④ Wheezing
⓪①②③④ Chronic cough
⓪①②③④ Shortness of breath
⓪①②③④ Cough up phlegm
⓪①②③④ Smoker
⓪①②③④ Shallow breather

Musculoskeletal

⓪①②③④ Joint pains
⓪①②③④ Stiff joints
⓪①②③④ Arthritis
⓪①②③④ Osteoporosis
⓪①②③④ Receding gums
⓪①②③④

Mind

⓪①②③④ Poor memory
⓪①②③④ Confusion, poor comprehension
⓪①②③④ Poor concentration
⓪①②③④ Slurred speech
⓪①②③④ Leaning difficulties

Head / ears

⓪①②③④ Headaches
⓪①②③④ Migraines
⓪①②③④ Earache
⓪①②③④ Ear infection
⓪①②③④ Itchy ears
⓪①②③④ Ringing ears

Skin

⓪①②③④ Acne
⓪①②③④ Eczema
⓪①②③④ Psoriasis
⓪①②③④ Rashes / hives
⓪①②③④ Excessive sweating
⓪①②③④

Cardio-vascular

⓪①②③④ Palpitations
⓪①②③④ High blood pressure
⓪①②③④ Breathlessness
⓪①②③④ Poor circulation
⓪①②③④

Genito-urinary

⓪①②③④ Increased frequency
⓪①②③④ Painful urination
⓪①②③④ Previous infections / cystitis
⓪①②③④ Need to go at night
⓪①②③④ Difficulty starting / stopping
⓪①②③④ Rarely needs to urinate
⓪①②③④ Frequent urges to urinate

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Weight

0 1 2 3 4 Overweight
0 1 2 3 4 Underweight
0 1 2 3 4 Gain weight easily
0 1 2 3 4 Difficult to lose weight
0 1 2 3 4 Dieting hasn't worked
0 1 2 3 4 Exercise doesn't help
0 1 2 3 4 Weight gain around hips
0 1 2 3 4 Weight gain around abdomen
0 1 2 3 4 Weight gain all over

Digestion

0 1 2 3 4 Bloating
0 1 2 3 4 Diarrhea
0 1 2 3 4 Constipation
0 1 2 3 4 Heartburn / reflux
0 1 2 3 4 Indigestion
0 1 2 3 4 Intestinal cramps / pain
0 1 2 3 4 Excess belching / burping
0 1 2 3 4 Gas, bottom end / flatulence
0 1 2 3 4 Nausea vomiting
0 1 2 3 4 Bad breath
0 1 2 3 4 Coated tongue
0 1 2 3 4 Have pets eg cats, dogs, farm animals
0 1 2 3 4 International travel

Dental

0 1 2 3 4 Fillings
0 1 2 3 4 Mercury fillings
0 1 2 3 4 Root canals
0 1 2 3 4 Frequent infections
0 1 2 3 4 Other dental work

Women / hormones

0 1 2 3 4 Irregular periods
0 1 2 3 4 Painful periods
0 1 2 3 4 Heavy periods
0 1 2 3 4 Long term contraceptive pill
0 1 2 3 4 PMT / PMS / mood swings
0 1 2 3 4 Menopause / hot flushes
0 1 2 3 4 Dark blood clots

Thyroid

0 1 2 3 4 Tired / sluggish
0 1 2 3 4 Hair loss
0 1 2 3 4 Miscarriages
0 1 2 3 4 Infertility
0 1 2 3 4 Cold hands and feet
0 1 2 3 4 Gains weight easily
0 1 2 3 4 Flush easily

Dominant emotions

0 1 2 3 4 Anger / aggressiveness
0 1 2 3 4 Anxiety / nervousness
0 1 2 3 4 Depression
0 1 2 3 4 Fear
0 1 2 3 4 Mood swings
0 1 2 3 4 Joy
0 1 2 3 4 Worry
0 1 2 3 4

Food

0 1 2 3 4 Shaky / faint if hungry
0 1 2 3 4 Palpitations if hungry
0 1 2 3 4 Awaken in early hours of morning
0 1 2 3 4 Hard to get back to sleep
0 1 2 3 4 Need coffee, chocolate or sweets when tired
0 1 2 3 4 Craves sweets
0 1 2 3 4 Thirsty much of time
0 1 2 3 4 Diabetes in family history
0 1 2 3 4 Are vegetarian / vegan

Stress / adrenals

0 1 2 3 4 Significant stress / emotional issues
0 1 2 3 4 Crave salt
0 1 2 3 4 Always tired
0 1 2 3 4 Long time to wake in morning
0 1 2 3 4 Lightheaded or dizzy, especially on rising from sitting or lying
0 1 2 3 4 Irritable / nervous stomach
0 1 2 3 4 Anxiety / nervousness / depression
0 1 2 3 4 Decreased sex drive
0 1 2 3 4 My tolerance has decreased
0 1 2 3 4 Colds last longer than a week
0 1 2 3 4 Chronic fatigue
0 1 2 3 4 Allergies
0 1 2 3 4 Sensitive to bright lights

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List your top three or more conditions that you would like to be helped:

1.
2.
3.
4.
5.

Grade how well you sleep

Very well — Very poorly

Grade your stress levels at work

No stress — Highly stressed

Grade your stress levels outside of work

No stress — Highly stressed

How often do you exercise?

Never — Daily exercise

Do you relax, meditate, visualise quietly?

Never — Daily relaxation

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The foods you eat and lifestyle:

On average how many times do you eat / drink the following per day or week, or enter in your own frequency i.e. coffee, twice per week

Are you vegetarian?	Yes / No	
Do you smoke?	Yes / No	How many per day ?
Approximately what time to your on to bed usually?		

Glasses of water	Per day:
Coffee / tea	Per day:
Red meat	Per week:
Pieces of fruit	Per day:
Portions of vegetables	Per day:
Chicken portions	Per week:
Oily fish	Per week:
Glasses of Milk	Per week:
Wheat bread / pasta	Per week:
Portions of cheese	Per week:
Sugar, cakes, fizzy drinks	Per week:
Units of alcohol	Per week:
Meals out of a packet	Per week: