PATIENT INFORMATION

Name

Date of Birth

Occupation

Height_____

Weight_____ BMI_____

Address

Marital Status

Email _____

Mobile_____

No. of Children: Boys_____ Girls_____

G.P._____

Phone_____

When was your last visit to the G.P?_____

What was it for?_____

Do you smoke? No Yes How many per day?_____ How many years?_____

Do you drink alcohol? No Yes How much?_____

Do you take drugs? No Yes List names_____

Do you take vitamins? No Yes List names_____

Do you exercise? Regularly_____ Infrequently_____ Seldom_____

Are you pregnant? No Yes No. of Weeks_____ EDD_____ Last Period _____

Are you taking any medications? No Yes List names_____

_____

Do you have a pacemaker? No Yes

MEDICAL HISTORY

Parents living: Father (age)_____ Mother (age)_____

Brothers:_____ Sisters_____

Family History

Mental Disease No Yes Who?_____ Asthma No Yes Who?_____

Heart Disease No Yes Who?_____ Cancer No Yes Who?_____

Lung Disease No Yes Who?_____ Arthritis No Yes Who?_____

Special Needs No Yes Who? _____ Diabetes No Yes Who? _____

Allergies No Yes Who?_____ List them_____

Any Other (specify)_____

Childhood Illness

Measles _____ Mumps _____ Chicken Pox _____ Rubella _____

Unusual Childhood Diseases_____

Immunisations No Yes List names, dates and reactions

Allergies (including details of anaphylaxis and how the reaction was handled)

Previous Medical Conditions (including dates)

Injuries (slips, falls, car accidents etc.) ?_____

Any back complaints?_____

Illnesses?_____

Operations?_____

Surgical/Trauma Scars? _____

Medical Procedures?_____

If you suffer from exhaustion or fatigue, describe in your own words how you feel and what time of day or night you experience these symptoms, including whether they occur daily, occasionally etc.

Would you say that you are under a lot of stress?_____ If yes, explain _____

Do you experience undue worry, difficulty in concentrating, forgetfulness, failing memory, etc.?

Female: Do you experience pain or discomfort before, during or after menstrual cycle (regardless of whether you menstruate, are in menopause or have had surgical removal of all or part of the reproductive organs or skip your period occasionally)? Do you suffer from PMT? Do you suffer from PCOS? Do you suffer from irregular cycles? Do you suffer from dysmenorrhoea? Specify other.

Current Treatments Receiving

Chief Complaint (describe fully)

Duration of condition? _____

What do you believe caused this condition?_____

List all foods and beverages taken more than three times per week_____

_____

_____

_____

Do you suffer from any of these symptoms: Only complete column **B**

B	A		B	A	
		Headaches			Excessive Gas
		Hot Flushes			Insomnia
		Blurred Vision			PMT
		Dizziness			Poor Memory
		Morning Fatigue			Sexual Impotency
		General Fatigue			Excessive Perspiration
		Laboured Breathing			Palpitation of the Chest
		Shortness of Breath			Dry Skin
		Indigestion			Poor Appetite
		Heartburn			Excessive Appetite
		Lump in the Throat			Night Sweats
		Throat Constriction			Nerves
		Numbness			Depression
		Fainting Spells			Learning Disabilities
		Light Headedness			Asthma
		Swelling of the Joints			Chemical Sensitivities
		Loose Stools			Constipation
		Candida			ADHD
		Arthritis			Pain Disorders

TO BE COMPLETED BY THE PRACTITIONER

Temperature _____

Pulse _____

Respiration _____

Blood Pressure _____

Spinal Curvature or Surgical Implants _____

General Appearance/ Behaviour _____

_____

_____

_____

_____

I..... understand that Amanda Philipe-Savage does not claim to cure or diagnose any illness or disease with any treatment and specifically Kinesiology, NAET, Bowen, Reiki or any other treatment offered by her.

I understand the treatments and tests

- do not diagnose disease, various standard medically proven measures are used, including: kinesiology, range of movement assessment and body fluid results. The testing techniques give an indication to the best course of treatment needed.

I understand that *'I am / my ward' is to:*

- continue all medications and other treatments given by other doctors as they are prescribed unless otherwise directed by the doctor who prescribed them.
- follow the instructions received or the treatment may not work, and I may have a sensitivity reaction. The treatments will need to be followed up and a repeat procedure may be necessary.
- **disclose any previous anaphylaxis (sensitivity reaction) before treatments can commence so that every care can be taken to avoid direct contact with allergens and treatments.**
- give permission for my case study to be used in the future for research and educating other patients without it disclosing my identity, e.g. photographs, lab results, x-ray & measurement data.

Your data will be stored securely and will be retained for 7 years after your last appointment then be disposed of securely. You will be shown my full GDPR policy for your perusal. I agree to being contacted by Amanda Philipe-Savage by email, phone or text.

You may freely ask questions about this form or the treatment, now or at any time during your treatment. If you experience any after effects or if you have any questions about your treatment you may contact your practitioner, Amanda Philipe-Savage by email, phone or text.

Summary of Procedures at Clinic visits	**First Consultation 60 – 90 minutes**	**Follow-Ups 30 - 45 minutes**
Review of your health & medical history to assess the best treatment	X	
Collection of information on your lifestyle and work	X	
Review other visits hospital / GP for treatment for any symptoms	X	X
Assessment of symptoms	X	X
Completion of questionnaires according to your symptoms	X	X
General physical health check	X	X
Discuss Information Sheet and Consent	X	
Treatments given as needed	X	X
Review the changes in health / medications since last visit		X

I have read / *had read* to me the above statements and have had the opportunity consider the information and ask questions. Procedures and follow up actions have been described. I understand that if I am anaphylactic I must attend with a surrogate and that treatments will be performed through them. By signing below, I agree to the terms and conditions and take full responsibility for accepting the treatment and outcome.

Patient Signature	Print Name of Patient	Date
Guardian Signature	Print Name of Guardian	Date