Britta Woermann BSc (Hons), LicAc, MBAcC

Initial Consultation Form

Patient Details

Name:
Address:

Postcode:
Home Phone:
Work Phone:
Mobile Phone:
E-mail address:
Date of Birth:
Status: employed / retired / student / unemployed
Occupation:

GP's Name:
GP's Address:

GP's Phone No:
Patient's agreement to notify GP: Yes/No

Personal History

1. Medical History / Surgery / Accident

_____
_____
_____
_____
_____

2. Current Medication

_____
_____
_____

3. Family Medical History

_____
_____
_____

4. Do you consume any wine, alcohol, or tobacco? If yes, quantity and frequency?

_____
_____

5. Are you taking any exercise?

_____
_____

Presenting Conditions in Initial Consultation [For Both M/F]

Condition 1: _____

Duration: _____

Site: _____

Onset: _____

Radiating: _____

Associated symptoms: _____

_____

Exacerbating / Alleviating: _____

Weather _____ ; Heat or Cold _____

Rest or Movement _____

Time: _____

Severity: _____

Condition 2: _____

Duration: _____

Site: _____

Onset: _____

Radiating: _____

Associated symptoms: _____

_____

Exacerbating / Alleviating: _____

Weather _____ ; Heat or Cold _____

Rest or Movement _____

Time: _____

Severity: _____

Observations / Inquires

1. Do you tend to feel hot or cold? hot cold normal
   degree: _____ location: _____
2. Any daytime or night sweat: No; Yes night sweat day-time sweat
3. How is your energy level (0 – 10, 0 lowest) _____
4. How is your sleep quality: Good; difficulty in falling asleep; difficulty in maintaining asleep; Dream a lot; wake up feeling restlessness
5. Appetite: Good Low; diet: _____ meals; ingredients: _____
   _____
6. Do you usually feel thirsty? no yes & desire a sip yes desire lots of water
7. Stools:
   Regularity: Regular _____ Irregular _____
   Moist: Watery (Diarrhoea) Soft and well-shaped Hard (Constipation)
   Interchange between diarrhoea and constipation
   Shape: usually formed _____; not formed
   Colour: light brown brown dark brown not sure
   Blood or Mucous (circle): no; yes, within stools; yes, covering stools
   Sensation after passing (for diarrhoea/constipation): relieved; exhausted
8. Urination:
   Frequency & Amount: _____
   Colour: pale pale-yellowish yellow dark cloudy
9. Discomfort/Location in: Head (headache or migraine) Chest (respiration or palpation) Abdomen (bloating, soreness, pain)
   _____
10. Abnormality in sensation: Hearing (tinnitus) dizziness Hair, Teeth Eyesight (short / long / blurred vision / floaters)
11. Others:
    _____

_____

Further Questions for Female Patient

Aim for pregnancy (continue Qs below) Not for pregnancy (to Qs @ right)

1. How long have you been trying? _____
2. Have your partner been checked? yes and normal; yes low sperm count(<20million/ml) low motility(<50% vigorous) <14% morphology no (suggest to proceed check up)
3. Have you been checked-up? No; Yes normal
   hormonal problems tube blockage endometriosis (w/ pain, w/o pain)
   PCOS fibroids; size _____ PID
   _____
   _____
4. Are you ovulating? yes no don't know
   Any feeling during ovulation? _____
5. Do you notice any sings of fertile mucus at mid cycle? No; Yes thick & pasty (G) sticky & wet (L) stretchy, slippery (egg-like) (S) less sticky & stretchy yet very lubricative (P); Q'ty: _____

Menstruation Qs

1. Age of first period: _____
2. Cycle length: Regular, days _____; Irregular, early / late / no clear pattern
   Day in terms of cycle: _____ Bleed in between cycles _____
3. Duration: _____ days
4. Flow: scanty; light; normal; heavy, frequency of changing _____
5. Colour: light red bright red dark red
6. Clots: No Yes; small Yes; large (>£1 coin) _____
5. Pain experienced before, during or after periods No, Yes; before & during (Qi & Blood stagnation / Cold in uterus) Yes, after (KI / Qi+Blood Xu)
   Since: _____
   Location: low abdomen esp. both sides low abdomen esp.central sacrum
   Nature: dull intense & stabbing intense & cramping down-bearing
   Pressure: like dislike
   Sensation: relieved after passing clots tired after period
6. PMT: No Yes, when _____

6. Do you have sexual intercourse around ovulation? yes no
7. Do you have your Basal Body Temperature recorded? yes no (suggest to start from Day1 of next period for 3 cycles)
8. Any other functional problems? No; Yes ectopic pregnancy miscarriage abortion that damage endometrium thyroid problem_____
9. What's your lifestyle like?

   _____
10. Is your emotion stable? Yes; Not really feeling stress feeling anxious irritable
11. Using HRT?_____
12. Where are you in your cycle?_____

S+S: feeling irritable/depressed; breast swelling & soreness

_____

7. Contraception: yes No; Not now, history of using for _____ (duration)
8. History of pregnancy or abortion: _____

   _____
9. Mother's or sister's pregnancy histories:

   _____

   _____

[Summary or Additional Information]

_____

_____

_____

_____

Questions for [Male Infertility] patient

Condition: _____

Duration: _____

Observations / Inquires

1. Do you tend to feel hot or cold? hot cold normal
   degree: _____ location: _____
2. Any daytime or night sweat: No; Yes night sweat day-time sweat
3. How is your energy level (0 – 10, 0 lowest) _____
4. How is your sleep quality: Good; difficulty in falling asleep; difficulty in maintaining asleep; Dream a lot; wake up feeling restlessness
5. Appetite: Good Low; diet: _____ meals; ingredients: _____

   _____
6. Do you usually feel thirsty? no yes & desire a sip yes desire lots of water
7. Stools:

   Regularity: Regular _____ Irregular _____

   Moist: Watery (Diarrhoea) Soft and well-shaped Hard (Constipation)

   Interchange between diarrhoea and constipation

1. How long have you been trying? _____
2. Have you checked sperm quality & quantity? yes and normal; yes low sperm count(<20million/ml) low motility(<50% vigorous) <14% morphology no (suggest to proceed check up)
3. Any functional or organ-related obstruction? no; yes_____

_____

[Summary of Observation / Additional Information]

_____

_____

_____

_____

_____

Shape: usually formed _____; not formed

Colour: light brown brown dark brown not sure

Blood or Mucous (circle): no; yes, within stools; yes, covering stools

Sensation after passing (for diarrhoea/constipation): relieved; exhausted

8. Urination:

   Frequency & Amount: _____

   Colour: pale pale-yellowish yellow dark cloudy

9. Discomfort in head (headache or migraine) chest (respiration or palpation) Abdomen (bloating, soreness, pain) _____
10. Abnormality in sensation: hearing (tinnitus) dizziness hair eyesight (short / long / blurred vision / floaters)
11. Others:

    _____