Natural Wellbeing
Holistic Therapist Sameena Gillmore
E sameena@natural-wellbeing.co.uk
H 01892 524448
M 07727 288670

Consultation Form

Name | Male/Female

Date of Birth | Height | Weight

Please take the time to fill out this form thoughtfully as it will enable me to spend more time in your consultation on your health concerns on the day.

Health Overview

Please summarise the health concerns that you would like to address

Please list the goals and aims you would like to achieve

Please list any medication and/or supplements you are currently taking or have taken in the past

How many courses of antibiotics have you had in your lifetime?

What vaccinations have you had?

Provide a brief overview of your medical history including childhood and teenage illnesses and any operations/hospital visits

Please list any significant illnesses of your parents/grandparents ie diabetes, heart disease, asthma etc.

Do you have any allergies? Please include your symptoms

Do you have any food intolerances? Please include your symptoms

Symptoms check list Do you suffer any problems with the following?

Digestion

- [ ] Bloating
- [ ] Constipation
- [ ] Wind
- [ ] Diarrohea
- [ ] Acid Reflux

How often are your bowel movements

Cardiovascular

- [ ] Osteoarthritis
- [ ] Rheumatoid Arthritis
- [ ] Back Pain
- [ ] Muscle Cramps
- [ ] Restless Leg
- [ ] Joint Pain

Skin

- [ ] Eczema
- [ ] Dermatitis
- [ ] Psoriasis
- [ ] Acne
- [ ] Dry/Greasy Skin
- [ ] Dandruff
- [ ] Dark circles under the eyes

Menstruating Women

- [ ] PMT
- [ ] Irritability
- [ ] Menstrual Bloating
- [ ] Heavy Flow
- [ ] Irregular Cycle
- [ ] Painful Periods
- [ ] Depression
- [ ] Fluid Retention

Menopausal Women

- [ ] Hot Flushes
- [ ] Mood Swings
- [ ] Depression
- [ ] Poor Sleep
- [ ] Vaginal Dryness

General Health

- [ ] Athletes Foot
- [ ] Cold Sores
- [ ] Headaches
- [ ] Lack of Sex Drive
- [ ] Lack of Sex Drive
- [ ] Low Fertility
- [ ] Migraines
- [ ] Poor Memory
- [ ] Poor Night Vision
- [ ] Poor Sleep
- [ ] Poor Wound Healing
- [ ] Thrush
- [ ] Sensitive to bright lights
- [ ] Thrush

What are your energy levels on a scale of 1-10

What are your stress levels on a scale of 1-10

List any emotional traumas / episodes, with rough dates, as far back as you like (Divorce, bereavements, divorce, parents split etc)

Food Plan Please describe your typical diet and also state if you skip meals.

Breakfast Time

Mid-morning Snack

Lunchtime

Mid-afternoon Snack

Dinnertime

Evening Snack

Drinks throughout the day

Cravings

Foods you dislike

Please 'Save' your consultation form and email it to me at sameena@natural-wellbeing.co.uk

Alternatively 'Print' it out and bring it along to your session...

Sameena Gillmore
Holistic Therapist