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07985 200805

Confidential Patient Record

Date:

Name:		
Address:		
Home phone no:		Work no:
Mobile:		Email:
Occupation		Date of birth
Do you live alone, or with a partner / family member(s) / friend(s)		If you have children, please state ages
Weight	Height	Blood pressure if known
Please briefly describe the condition(s) you are consulting me about:		

Please List any over the counter medications you regularly take (include antacids, pain relief pills, anti-histamines, anti-inflammatory drugs etc)

Name of medication	How frequently taken	Taken for what purpose

Please list any other pills you regularly take (such as herbal or nutritional supplements)

Name of supplement (inc. brand)	Dose	Length of time taken

Health Screen

Family History: Please indicate if any of the following conditions run in your family (M = Male; F =Female)

Condition	Grandparents		Parents		Siblings		Children	
	Paternal	Maternal						
	M	F	M	F	M	F	M	F
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma /Eczema / Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease/ Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IBS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IBD (Crohn's, Colitis, Coeliac's)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Symptoms list

The following symptoms all indicate areas needing attention. Please indicate whether you suffer from these symptoms as follows:

1 – Mild, occasional problem (maybe 1 x month)

2 – Moderate (maybe 1 x week)

3 – Severe (occurs frequently / daily)

1	2	3		1	2	3	
DIGESTIVE				EARS			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Itchy ears
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earache / ear infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Less than one bowel movement/day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drainage from ear
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bloating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tinnitus
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Belching and/or flatulence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
EMOTIONS				ENERGY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Apathy, lethargy
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger, irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperactivity
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty relaxing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Insulin and adrenal hormones				RESPIRATORY			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wake in middle of night feeling anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave sweet foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shaky or irritable when hungry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prone to cold sores or mouth ulcers
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sleepy after lunch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Husky voice
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sore tongue
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy when standing up suddenly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent need to clear throat
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave salty foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty getting up in morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest infection
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)

			NERVOUS SYSTEM				SKIN/NAILS/HAIR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Unexplained hair loss
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Acne
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Confusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema / dermatitis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urticaria / Heat rash
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poor physical co-ordination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Number of hours sleep Number hours unbroken sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Deterioration of fingernails (ridges, splits)
			Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	White spots on fingernails.
			EYES				CARDIOVASCULAR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Watery or itchy eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen, irritated eyelids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen ankles (especially at end of day)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to bright light	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eyes feel gritty				
			JOINTS/MUSCLES				WEIGHT
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aches/pains in joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Craving certain foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis / rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lack of appetite
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water retention
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shakiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Crave certain foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty losing weight
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle twitches (eg around eyes)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty gaining weight.
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Muscle tension (eg neck and between shoulder blades)				
			WOME				MEN
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty urinating
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Excessive facial/body hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Waking more than once per night to urinate
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PMT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy period	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scanty/ irregular periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thrush/ Cystitis				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Breast tenderness				
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other (please specify)

Women: Certain herbs and supplements should not be taken during pregnancy. If there is any possibility that you are pregnant now or if you become pregnant, please stop taking herbs and supplements until you have discussed this with me. Tick box to indicate you agree to this

Diet and Lifestyle

Is your diet based on any religious, personal or other choice (eg gluten-free, vegetarian, vegan, etc) ?

No Yes (please specify)

Do you have any allergies, intolerances or sensitivities that you know of or suspect?

No Yes (please specify)

Digestive speed / efficiency (completed by herbalist)

Do you smoke? No Yes

If you used to smoke, how long ago did you give up?

Would you describe yourself as:

Not very active Moderately active Very active

Please take a few moments to reflect on how your health affects your quality of life.

Does it limit your social life

Affect your relationship

Affect your work life

Other

Thank you very much for completing this information. It will help me to address your problems as effectively as possible.