Harmony Questionnaire 1st Session Date: _________

Please complete as accurately as possible. All information is confidential. If more space is required please continue on back of page or other sheet.

Name				Date of Birth			Office Use:		
Address 1				Telephone					
Address 2				Mobile					
Address 3		Postcode		Email					
Referred By				Doctor			Telephone		
Health Background									
Present Treatment	Inc. supplements & medication								
Occupation				Family					
Do you smoke?	Yes		If Yes, how many?	Do You Drink?	Yes		If Yes, how much?		
	No				No				
Do you use recreational drugs?	Yes		If Yes, what & how much?	What exercise do you take?	Inc. how long per week?				
	No								
Other relaxation?	How often/long per week?			Time you go to bed?		How many hours do you sleep?			
						Quality of sleep?	Good	Fair	Poor
What do you eat / drink for the following meals ...?									
Breakfast?									
Lunch?									
Evening?									
Between Meals?									
Height?				Weight?		Weight 5 years ago?			
Was there anything abnormal about your birth?				e.g. premature, delivery, etc					
Did you have normal childhood vaccinations?				Yes		Any vaccinations since? Dates?			
				No					
What was your health like in childhood?									
List any operations / accidents / illnesses with approximate dates									
List any medication/drugs taken over long period									
List any emotional traumas with approximate dates									

Conditions – Please indicate those that apply to you by placing the relevant number next to the condition.

'1' for MILD '2' for MODERATE '3' for SEVERE

I have had	I am having		I have had	I am having	
		Poor sleep			Regular colds
		Vertigo			Respiratory infections
		Hearing problems / tinnitus			Constipation
		Dyslexia			Loose bowels
		Fainting			High blood pressure
		Epilepsy			Low blood pressure
		Nervous twitching			Poor circulation
		Headaches			Cold hands and feet
		Migraines			Anaemia
		Sight problems			Chronic tiredness / lethargy
		Anxiety attacks			Thrush / candida
		Depression			Menstrual problems
		Physical abuse			Prostate gland problems
		Emotional abuse			Urinary problems
		Sexual abuse			Sexual dysfunction
		Chest pains			Liver /gallbladder problems
		Neck / shoulder / arm pain			Kidney problems
		Low back pain sciatica			Blood sugar problems
		Osteoporosis			Asthma
		Arthritis			Hay fever
		Leg/knee pain			Skin allergies / rashes
		Painful feet			Other allergies (specify)
		Jaw problems			
		Dental problems			Food cravings (specify)
		Other pain (specify)			

Please list in order of importance the problems that you would most like help with:			
1.		2.	
3.		4.	
5.		6.	

Please read and sign below:

I understand that practitioners at 'Harmony' do not give medical diagnosis or treatment but assess imbalances that are revealed in a session and use gentle therapeutic methods to enhance health and well being. These procedures should be regarded as 'complementary' to conventional healthcare rather than an 'alternative' to it. I appreciate it is my responsibility to consult my Doctor on any issue that I am aware of, or am alerted to as a result of this or subsequent appointments.

I give my consent to be touched in an appropriate manner for the consultation and to receive gentle, natural, therapeutic treatment in keeping with the format of the appointment.

I agree to give at least 24 hours notice of cancellation and if not will pay the full fee.

Signed:	Date: