THE PERRYMOUNT

Christian Bates Bsc(Hons) Ost. Med. DO ND

Registered Osteopath & Naturopath, Certified Metabolic Typing Advisor

OSTEOPATHY & NATURAL HEALTH CLINIC

Name:			Date of Birth	:
Address:				
			Postcode:	
Home No:	Mobile:		Work No:	
Email:			Occupation:	
Name of private health cover:	Po	licy No's:	Todays Date:	
How did you hear about the cl	inic?			
Yellow pages yell.com website Bright Fm radio Local newspaper BT phone book Lindfield Life Internet/google search		Friend, fam Sign outside GP referral Website Dolphin sur		
Do you have any known allerg	gies? Yes No			·
Any unusual childhood illnes	ses? Yes No			
Are you on any medication or	supplements?	Yes No		
Have you ever taken steroids	or antibiotics?	Yes No		
Have you had any operations	(in your entire life pl	ease)? [Yes [No	
Do you have any named cond	itions / disease? ie d	iabetes, high blood	l pressure, cancer etc?	Yes No
Have you had any X-rays, blo	od tests or other inve	estigation? []Ye	es No	
Do you have any problems th anything else? Yes No		or example heart d	isease, high blood press	ure, diabetes, cancers or

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Signature:

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to be effective and safe I may have to remove some of the top layers of my clothing so that the osteopath can examine

Date:

me fully. We may also send you occasional newsletter with health information and special offers.

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Answer all symptoms as they have been over the last 30 days or since you last filled out this form, which ever was most recent. Simply cross or fill in the appropriate score for each symptom. Use the following scale:

0 ● 2 3 40 1 ● 3 40 1 2 ● 4	No symptoms at all Suffer occasionally / mild Suffer often / moderate Suffer often / severe Suffer frequently / severe		
Nasal .	/ sinus	Head	/ ears
	Post nasal drip		Headaches
00234		00034	Migraines
00234		00034	
00034			Ear infection
00234	Sneezing	00234	•
Lu	ngs	01234	Ringing ears
	Asthma	Sk 00234 00234 00234	Eczema
	Cough up phlegm		Rashes / hives
		00234	Excessive sweating
00234	Shallow breather	00234	_
Musculo	oskeletal		vascular
00234 00234 00234 00234 00234	Joint pains Stiff joints	00234	Palpitations High blood pressure Breathlessness Poor circulation
00234		Genito	-urinary
00034 00234 00234 00234	ind Poor memory Confusion, poor comprehension Poor concentration Slurred speech Leaning difficulties	00234 00234 00234 00234 00234	Increased frequency Painful urination Previous infections / cystitis Need to go at night Difficulty starting / stopping Rarely needs to urinate Frequent urges to urinate

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Weight

0	1	2	③	4	Overweight

- **(90) (1) (2) (3) (4) (1) (2) (3) (4) (1) (4) (5) (4) (4) (4) (4) (5) (4) (4) (4) (4) (4) (5) (4)**
- 00034 Gain weight easily
- OOO Difficult to lose weight
- 00234 Dieting hasn't worked
- ①①②③④ Exercise doesn't help
- 00034 Weight gain around hips
- 00000 Weight gain around abdomen
- @①②③④ Weight gain all over

Digestion

- **(1)(2)(3)(4)** Bloating
- **01234** Diarrhea
- 00234 Constipation
- 00234 Heartburn / reflux
- 00234 Indigestion
- 00234 Intestinal cramps / pain
- 00234 Excess belching / burping
- 00234 Gas, bottom end / flatulence
- 00034 Nausea vomiting
- **00234** Bad breath
- @@@@@Coated tongue
- 00234 Have pets eg cats, dogs, farm animals
- 00234 International travel

Dental

- **01234** Fillings
- **00034** Mercury fillings
- **000234** Root canals
- **00234** Frequent infections
- 00234 Other dental work

Women / hormones

- **(1) (1) (2) (3) (4) (3) (4) (5) (5) (6) (4) (7)**
- **10 10 20 34** Painful periods
- 00234 Heavy periods
- 00234 Long term contraceptive pill
- **10 10 20 34** PMT / PMS / mood swings
- 00234 Menopause / hot flushes
- (0)(1)(2)(3)(4) Dark blood clots

Thyroid

- ①①②③④ Tired / sluggish
- (1)(1)(2)(3)(4) Hair loss
- **00234** Miscarriages
- 00234 Infertility
- 00234 Cold hands and feet
- 00234 Gains weight easily
- 00234 Flush easily

Dominant emotions

- 00234 Anger / aggressiveness
- ①①②③④ Anxiety / nervousness
- 00234 Depression
- 00234 Fear
- **10 10 20 34** Mood swings
- **00234** Joy
- 01234 Worry
- 001234

Food

- ①①②③④ Shaky / faint if hungry
- 00234 Palpitations if hungry
- 00234 Awaken in early hours of morning
- @@@@@ Hard to get back to sleep
- (0)(1)(2)(3)(4) Need coffee, chocolate or sweets when tired
- **01234** Craves sweets
- (0(1)(2)(3)(4) Thirsty much of time
- **00234** Diabetes in family history
- 01234 Are vegetarian / vegan

Stress / adrenals

- ①①②③④ Significant stress / emotional issues
- **10 10 20 34** Crave salt
- 00000 Always tired
- 00234 Long time to wake in morning
- 01234 Lightheaded or dizzy, especially on rising from sitting or lying
- 01234 Irritable / nervous stomach
- ①①②③④Anxiety / nervousness / depression
- ①①②③④ Decreased sex drive
- 00234 My tolerance has decreased
- 00234 Colds last longer than a week
- 00234 Chronic fatigue
- 00030 Allergies 00030 Sensitive to bright lights

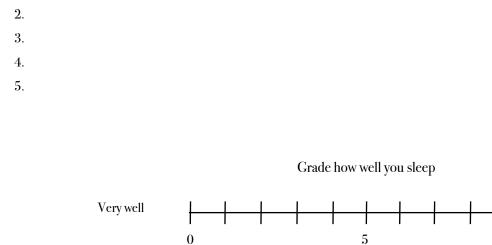
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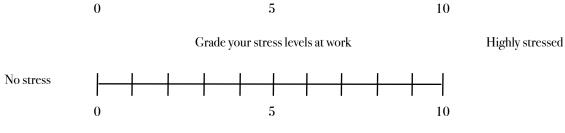
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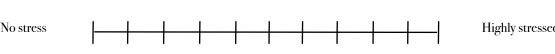
List your top three or more conditions that you would like to be helped:

1.

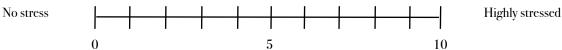


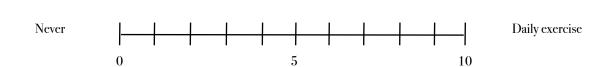




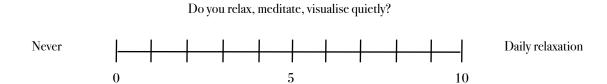


Grade your stress levels outside of work





How often do you exercise?



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The foods you eat and lifestyle:

On average how many times do you eat / drink the following per day or week, or enter in your own frequency i.e. coffee, twice per week

Are you vegetarian? Yes / No

Do you smoke? Yes / No How many per day?

Approximately what time to your on to bed usually?

Glasses of water Per day: Coffee / tea Per day: Red meat Per week: Pieces of fruit Per day: Portions of vegetables Per day: Per week: Chicken portions Oily fish Per week: Glasses of Milk Per week: Wheat bread/pasta Per week: Portions of cheese Per week: Sugar, cakes, fizzy drinks Per week: Units of alcohol Per week: Per week: Meals out of a packet