HELIX HOUSE NATURAL HEALTH CENTRE
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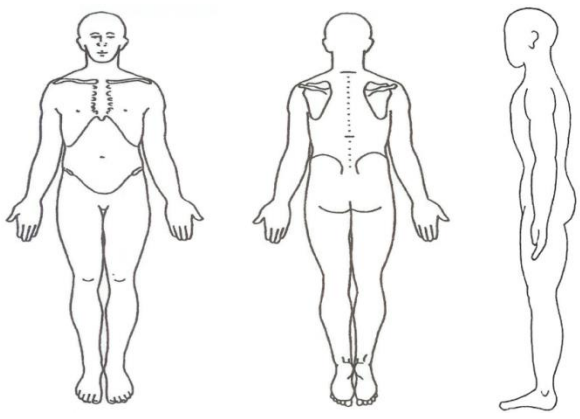
Preliminary Questionnaire

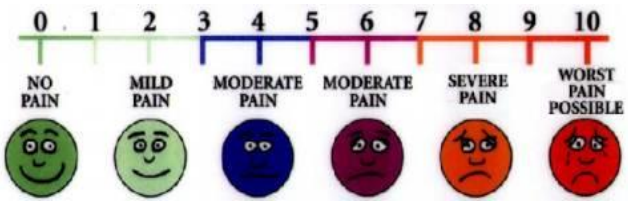
Please fill in this questionnaire as accurately as you can to assist us in understanding your symptoms and to enable us to focus more quickly on the root causes of your particular problem.

Date	Name		
Address			
Postcode	Email		
Tel: Work		Home	Mobile
Date of Birth	Occupation		
What is your main symptom/problem?			
When did it start?	What caused it?		
What eases it?	What aggravates it?		

If appropriate, please mark on the diagram below your areas of pain/concern



How severe is it? It would be helpful for us to know how severe you find your condition to be. **Please circle or state the number which best rates to your presenting problem today**



Please note any other symptoms/problems you may have:

Have you consulted your GP?	If yes, what was diagnosed and what treatment, if any, was prescribed?
Did it help?	Any side effects?
Have you consulted any other therapist?	If yes, what was diagnosed and what treatment, if any, was prescribed?
Did it help?	Any side effects?

Are you on any medication?	If yes, what?
Dosage	For what was it prescribed?

Is your condition having an adverse effect on your life?	In what way?

Have you had any major falls, accidents or injuries? Please detail any of these in the table below:			
What happened?	When?	Resulting injury?	Treatment?

Have you had any serious illnesses, operations or hospital stays? Please detail any of these in the table below:			
What happened?	When?	Treatment?	Recovered?

If it were not for the above factors, would you be

- Happy?
- Fit?
- Healthy?

If not, please briefly state why:

GP Name	May we write? ☐ Yes ☐ No
GP Address	

Please tell us how you heard about Helix House:

☐ 1. Friend ☐ 5. Yellow Pages ☐ 9. Press Article

☐ 2. Family ☐ 6. Green Pages ☐ 10. Perrin Website

☐ 3. GP ☐ 7. Sunflower Trust ☐ 11. Internet Search (specify search engine)

☐ 4. Another practitioner ☐ 8. Helix House Website ☐ 12. Other (specify)

Please give the name of the person who referred you, so that we can thank them:

May we write? ☐ Yes ☐ No

For office use only: Category of presenting complaint

1. Spine 2. Head 3. Upper Extremity 4. Lower Extremity 5. Learning Difficulties
6. Psychological 7. Allergies 8. Weight/Fitness 9. System Disorders 10. CFS/ME
11. Other

Medical Symptoms Questionnaire (MSQ)

Patient Name _____ Date _____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0– ***Never or almost never*** have the symptom
1– ***Occasionally*** have it, effect is ***not severe***
2– ***Occasionally*** have it, effect is ***severe***
3– ***Frequently*** have it, effect is ***not severe***
4– ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **Total** _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **Total** _____
(Does not include near or far-sightedness)

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **Total** _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **Total** _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discoloured tongue, gums, lips
_____ Canker sores **Total** _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **Total** _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain **Total** _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____	Chest congestion	
_____	Asthma, bronchitis	
_____	Shortness of breath	
_____	Difficulty breathing	**Total** _____

DIGESTIVE TRACT

_____	Nausea, vomiting	
_____	Diarrhoea	
_____	Constipation	
_____	Bloated feeling	
_____	Belching, passing gas	
_____	Heartburn	
_____	Intestinal/stomach pain	**Total** _____

JOINTS/MUSCLE

_____	Pain or aches in joints	
_____	Arthritis	
_____	Stiffness or limitation of movement	
_____	Pain or aches in muscles	
_____	Feeling of weakness or tiredness	**Total** _____

WEIGHT

_____	Binge eating/drinking	
_____	Craving certain foods	
_____	Excessive weight	
_____	Compulsive eating	
_____	Water retention	
_____	Underweight	**Total** _____

ENERGY/ACTIVITY

_____	Fatigue, sluggishness	
_____	Apathy, lethargy	
_____	Hyperactivity	
_____	Restlessness	**Total** _____

MIND

_____	Poor memory	
_____	Confusion, poor comprehension	
_____	Poor concentration	
_____	Poor physical coordination	
_____	Difficulty in making decisions	
_____	Stuttering or stammering	
_____	Slurred speech	
_____	Learning disabilities	**Total** _____

EMOTIONS

_____	Mood swings	
_____	Anxiety, fear, nervousness	
_____	Anger, irritability, aggressiveness	
_____	Depression	**Total** _____

OTHER

_____	Frequent illness	
_____	Frequent or urgent urination	
_____	Genital itch or discharge	**Total** _____
		Grand Total _____