MEHER CLINIC - PREGNANCY/BIRTHING QUESTIONNAIRE DATE:-

Complete and Send to Meher Clinic 19 Meher Rd,. Woombye Qld. 4559 Australia.
Or Fax- (07) 5442 1700, Overseas - 61 7 5442 1700

NAME: .....

STREET: ..... FIRST PREGNANCY(Y/N)……..

TOWN/CITY.....STATE…… PREVIOUS CHILDREN(Y/N).....

Post/ZipCode.....……COUNTRY……AGES…….....

PHONE No. - Home.....……Work……..... YOUR BIRTH DATE.....

IThe following questionnaire helps us to evaluate your present medical status and any body imbalances. All information is absolutely confidential. The questions are for medical use and not to make a personal judgement or test.

MEDICATIONS:-List any medications/herbs/remedies you are presently taking:

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PAST OPERATIONS/ILLNESS/DISEASES

.....
……..

INSTRUCTIONS: **Circle the number which best represents the intensity of your symptoms/condition during the last 3-6 months. IF SYMPTOM/CONDITION is PRESENT MARK-**
1 = Mild, 2 = Moderate, 3 = Severe/Strong
IF YOU DON'T KNOW THE ANSWER OR IF SYMPTOM/CONDITION IS NOT PRESENT THEN LEAVE BLANK.
IF YOU HAVE ONLY HAD SYMPTOM SINCE BEING PREGNANT PUT ' P ' NEXT TO SYMPTOM

ENERGY-
1-Are you tired 1 2 3
If yes how long-.....
Chronic Fatigue 1 2 3
Best Time of Day/Night.....
Worst Time of Day/Night.....

APPETITE / LIKES / DISLIKES
1-Excessive appetite 1 2 3
2-Poor appetite 1 2 3
3-Food bloats 1 2 3
4-Like salty taste 1 2 3
6-Like sweet taste 1 2 3
7-Like sour taste 1 2 3
8-Like hot/spicy taste 1 2 3
9-Love Milk 1 2 3
10-Fatty Food upsets 1 2 3
11-Dairy Upsets 1 2 3
List food cravings.....
List food dislikes.....

DIZZINESS /CRAMPING
1-Dizziness 1 2 3
2-Cramping 1 2 3
*Where?(*legs etc.).....
3-Muscle spasms/tics 1 2 3
4-Muscle tension 1 2 3

THIRST
1-Very thirsty 1 2 3
2-Not very thirsty 1 2 3
3-Like cold drinks 1 2 3
4-Like hot drinks 1 2 3
6-Cups coffee/day .....
7-Cups tea/day .....
8-Quantity of soft drink/day .....
9-Quantity of water/day .....
10-Quantity of alcohol/day .....

PRESENT MEDICAL CONDITION/SYMPTOMS:
BODY TEMPERATURE
1-Feel generally hot 1 2 3
2-Hot face 1 2 3
3-Hot feet 1 2 3
4-Hot flushes 1 2 3
5-Feel generally cold 1 2 3
6-Cold feet 1 2 3
7-Cold hands 1 2 3
8-Cold buttocks 1 2 3
9-Feel hot inside/cold out 1 2 3
10-Wear lot of clothes 1 2 3
11-Wear few clothes 1 2 3

STOMACH / COLON
1-Poor digestion 1 2 3
2-Irritable bowel 1 2 3
3-Nausea 1 2 3
4-Nervous stomach 1 2 3
5-Heartburn 1 2 3
6-Acid reflux into mouth 1 2 3
7-Excess burping 1 2 3
8-Excess passing wind 1 2 3
9-Bad breath 1 2 3
10-Stomach ulcers 1 2 3
11-Rumbling in Stomach 1 2 3

SLEEP
1-Trouble getting to sleep 1 2 3
2-Frequent waking 1 2 3
Time you awake at night.....

PERSPIRATION
1-Excessive night sweats 1 2 3
2-Excessive day sweats 1 2 3
Location-Whole body...Face...Neck...Other..
Odour-Sour...Musty...Offensive...Other...
3-Clammy Hands 1 2 3

HEADACHES
Number/month.....
Location-Back of skull...Sides of head....
Temples...Forehead...Eyes...Top of Head...
Both sides...Left side...Right side.. Whole head...
Type of pain-Dull...Ache...Sharp...Splitting...
Pounding...Constant...Other.....
Migranes-…….
Time headaches start-.....
Menstrually Related…….

RESPIRATION / HEART/ NOSE
1-Asthma 1 2 3
2-Shortness of breath 1 2 3
3-Tight chest 1 2 3
4-Bronchitis 1 2 3
5-Heart palpitations 1 2 3
6-Heart beats fast 1 2 3
7-Irregular beat 1 2 3
8-Chest/Heart pain 1 2 3
9-Long term cough 1 2 3
10-Excess phlegm 1 2 3
Colour: Clear....White...Yellow...Green.....
11-Blocked sinus/nose 1 2 3
12-Runny nose 1 2 3
13-Post nasal drip 1 2 3
14 Hayfever (sneezing) 1 2 3

PAIN
1-Areas of pain.....
Type of pain-Sore...Ache...Sharp...Severe...
Throbbing...Stabbing...Burning...Other....
Worse :-1st movement..In bed...
Continued movement....Wet weather...
Cold....Heat....Other.....
Better:-Continued movement....Heat....Cold

PRESENT MENTAL / EMOTIONAL
1-Are you stressed 1 2 3
2-Anxious/Nervous 1 2 3
3-Angry 1 2 3
4-Frustrated 1 2 3
5-Restless 1 2 3
6-Hyperactive 1 2 3
7-Are you grieving 1 2 3
8-Depressed 1 2 3
9-Suicidal 1 2 3
10-Cry easily 1 2 3
11-Have mood swings 1 2 3
12-Poor memory 1 2 3
13-Confused mentally 1 2 3
14-Lack will 1 2 3
15-Bottle Emotions 1 2 3
16-Trouble relating 1 2 3
17-Feel unloved 1 2 3
18-Jealous/envious 1 2 3
19-Perfectionist 1 2 3
20-Obsessive 1 2 3
21-Have panic attacks 1 2 3
22-Bouts of mania 1 2 3
23-Had Nervous breakdown Y N
24-Lot of Grief in past Y N

DETAILS OF MENSTRUATION BEFORE PREGNANCY-
1-Have taken the pill Yes No
If Yes-How long-…….years
2-Were your cycles regular Yes No
3-Length of cycle(usually 28).....Days
4-Length of period.....……Days
5-Flow-Heavy….Light….Normal….Spotting...
Clots...Mucus....
6-Colour-Dark...Pale...Bright red...Purple...
Brown...Other.....
7-Pain with period 1 2 3
Cramping…….Better with heat……
8-.PMS.(P.M.T) 1 2 3
Symptoms:……
……..
Starts .....Days before period
9-Symptoms at ovulation.....

MORE QUESTIONS ON OTHER SIDE OF PAGE

URINATION
1-Excess daytime frequency 1 2 3
2-Excess night frequency 1 2 3
3-Difficult/slow urination 1 2 3
4-Dribbling after 1 2 3
5-With discomfort 1 2 3
6-Incontenence 1 2 3
7-Bladder infections 1 2 3
8-Blood in urine 1 2 3

VAGINAL /OVARIES
1-Do you have thrush Yes No
2-Excessive discharge Yes No
Colour-White...Yellow...Green...Other...
3-Vulval/Vaginal Rash Yes….No…4

BOWEL
1-Regular Yes No
2-Constipated 1 2 3
Stool very hard….hard...soft….
3-Diarrhoea 1 2 3
4-Loose unformed 1 2 3
5-Forceful diarrhoea 1 2 3
6-Alternate-Const. & Diarr. 1 2 3
7-Blood in/on stool 1 2 3
8- Mucus in/on stool Yes… No…
9- Undone feeling after Yes… No…
10- Pain with stool Yes… No…
11- Pain before stool Yes… No…
12-Haemorrhoids Yes… No…

CIRCULATION
1-PoorCirculation……..1 2 3
2-Thrombosis- Yes……No ……
3-Varicose Veins……1 2 3
4-Stroke Yes…….No ……..
5-Heart Attack Yes……No ……..

ALLERGIES/REACTIONS:
Dairy…Fatty/Greasy Foods...Wheat…Sugar...
Chocolate...Wine...Dust…Pollens…Feathers….
Other……
Are You Hypersensitive to Medicines /Chemicals/Perfumes Yes…1 2 3
No……

HAVE YOU MISSCARRIED BEFORE- Yes…**No**…
DETAILS: ……
……
……
Are you grieving still:-……..
IF PREVIOUS BIRTHS PLEASE GIVE DETAILS:-
Duration of each previous labour……
……
……
……
……
……
Pain Intensity (1-10)1st(Birth)……..2nd…… 3rd……4th……..

Post Natal Depression- ……..
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……
Have you had a history of depression other than Post natal- ……
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Any other complications etc.-……
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HOW MANY WEEKS PREGNANT ARE YOU:-……..

Symptoms with this pregnancy which are causing you concern:
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……
Do you have or have you been advised of any complications with this pregnancy:- ……
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Other relevant information:- ……
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How did you find out about our help with birthing:
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CLINIC USE:-

HOMEOPATHIC ASSESSMENT:-
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WESTERN ASSESSMENT :

T.C.M. DIAGNOSIS:-
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