MEHER CLINIC- HEALTH APPRAISAL QUESTIONAIRE **DATE:-** E

NAME:..... MARRIED/PARTNER.....

STREET:..... SINGLE/SEPARATED.....

TOWN.....Post Code……..NO.OF CHILDREN.....

Email(for newsletters/health info) **…….. AGES(If Young).....**
Home Ph.....……EMPLOYED..... YOUR BIRTH DATE.....
Work Ph…….....……TYPE of WORK ..... NAME HEALTH FUND.....

The following questionnaire helps us to evaluate your present medical status and any body imbalances from a Homeopathic, Chinese medical and Western medical perspective. Some of the questions are personal and help in giving a complete medical picture. 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:

.

PAST ILLNESS/DISEASES/OPERATIONS.....

.....Told about clinic or referred by-.....

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 = Intense/Strong**
IF YOU DON'T KNOW THE ANSWER OR IF SYMPTOM/CONDITION IS NOT PRESENT THEN LEAVE BLANK.

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.....

DIET
1-Do you eat vegetables Yes No
2- " " eat meat Yes No
3- " " eat salads/fruit Yes No
4-Approx. what % of diet is fruit/veg…..%

ENVIRONMENT
1-Best in hot weather Yes
2-Best in cold weather Yes
5-Worse in wet weather 1 2 3
6-Worse in dry weather 1 2 3

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
12-Wheat Upsets 1 2 3
List foods you have a lot of-……
……..
List food cravings.....

DIZZINESS /CRAMPING
1-Dizziness 1 2 3
2-Cramping 1 2 3
*Where?(*legs etc.).....
Worse in Summer…. Winter….
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-Cups coffee/day .....
4-Cups tea/day .....
5-Quantity of soft drink/day .....
6-Quantity of water/day .....
7-Alcoholic drinks/day .....

HAIR
1-Early Greying Yes No
What age did it start.....
2-Loss of hair Yes No

CLINIC USE:-

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
12 Stomach/Abdominal Pain/Discomfort
Yes...No...Where:-……..
Better……Worse…..with food.
13- Boating after food 1 2 3
14-Hiatus Hernia Yes….No…..
15- Are you tired , shaky or have headache
if you miss a meal Yes……No…..

SLEEP
1-Trouble getting to sleep 1 2 3
2-Frequent waking 1 2 3
Time you awake at night.....
3-Feet out of bedclothes Yes No

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...
Perspiration Stains- Yellow... Brown...

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
Other.....

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-Usual colour-Pale…Mid….Dark…
6-Incontenence 1 2 3
7-Bladder infections 1 2 3
8-Blood in urine 1 2 3

BOWEL MOTIONS
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…

HEARING
1-Deafness 1 2 3
2-Ringing 1 2 3
3-Industrial/sound damage Yes No

More Questions on other side of page:-

WOMEN- MENSTRUATION-
Answer the following if you have periods:-

1-Are you taking the pill Yes No
If Yes-How long-…….years
2-Are your cycles regular Yes No
3-Length of cycle(usual 28-30).....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,before period- 1 2 3
Cramping…….Better with heat……
8-P.M.T.(PMS) 1 2 3
Symptoms:……
Starts .....Days before period
9-Symptoms at ovulation.....

Answer if Periods Ceased/Ceasing-

1-Are you still having periods Yes…No…
If No- when did they stop-……..
2-Have you had a hysterectomy- Yes… No…
If Yes- Reason…….
3-If yes -do you still have ovaries Yes No
4-Going through menopause? Yes No
5-Are your periods becoming irregular Yes No

Vaginal /Ovaries / Uterus

1-Do you have thrush Yes No
2-Excessive discharge Yes No
Colour-White...Yellow...Green...Other...
3-Vulval/Vaginal Rash Yes….No…
4-Discomfort/pain with intercourse 1 2 3
5-Vaginal dryness 1 2 3
6-Ovary pain 1 2 3
Left.....Right.....Both....
7-Ovarian cyst/fibroids Yes No
8-Bearing down sensation 1 2 3
9-General pelvic pain 1 2 3
10-Abnormal pap smear Yes No
If Yes: Degree(CIN-)……
11-Uterine fibroids Yes No
12-Anti/Retroverted uterus Yes No
13-Loss of Libido 1 2 3

BREASTS

1-Breast Lumps 1 2 3
2-Sore to touch 1 2 3
3-Painful 1 2 3
4-Breasts swell 1 2 3

MEN

1-Erection problems 1 2 3
Physical……
Emotional/Anxious….
2-Premature ejaculation 1 2 3
3-Loss of sex drive/libido 1 2 3
4-Feel Generally Weak 1 2 3
5-Excessive drive 1 2 3

SKIN

1-Dry 1 2 3
2-Oily 1 2 3
3-Itchy 1 2 3
4-Bruise easily 1 2 3
5-Complexion-Pale...Red...Sallow...Dark...
6-*Eczema/Dermatitis* Yes No
Where?.....
Colour:- Red...Pink...White...Purple...
Weeps fluid- No..Yes..- Honey colour...Clear...

EYES / VISION

1-Sore eyes 1 2 3
2-Red 1 2 3
3-Dry or itchy or gritty 1 2 3
5-Puffy eyelids 1 2 3
6-Vision sometimes blurry 1 2 3
7-Floaties in field of vision 1 2 3
8-Bright lights bother 1 2 3

MOUTH / GUMS / THROAT/ TEETH

1-Mouth ulcers 1 2 3
2-Gums bleed 1 2 3
3-Long term sore throat 1 2 3
4-Itchy throat 1 2 3
5-Swollen neck glands 1 2 3
6-Are your teeth strong 1 2 3
7-Lot of fillings 1 2 3
Do you smoke cigarettes Yes… No…
If Yes – how many/day……..

FAMILY ILLNESS-(Parents,grandparents, brothers,sisters,uncles and aunts)

1-Cancer Yes No
2-Heart/Stroke Yes No
3-Diabetes Yes No
4-T.B. Yes No
5-Mental Yes No
6-Bone degeneration Yes No
7-Asthma/eczema Yes No
8- Dementia Yes No
Other.....
.....

MENTAL / EMOTIONAL

1-Are you stressed 1 2 3
2-Anxious/Nervous 1 2 3
3-Angry 1 2 3
4-Get over excited 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-Had Nervous breakdown Y N
23-Lot of Grief in past Y N
24-Depressed in past Y N

ALLERGIES/REACTIONS:

Dairy…Fatty/Greasy.Foods...Wheat.
Sugar..Chocolate..Red Wine..Dust…Pollens….
Feathers….Other…….

Are You Hypersensitive to Drugs/Chemicals /Perfumes Yes……1 2 3 No……
List……

CLINIC USE:-

EXAMINATION:

Ears.....Tonsils.....Neck….

Glands.....Gums.....Mouth Roof .....Leg Pulses…….

Chest.....Liver.....Stomach.....

Abdomen.....Lower Abdom.....

Hands.....Nails.....Reproductive.....

Eyes.....Blood Pressure - Usual...../..... Today……../……..

Blood Sugar.....Urine..... .Nasal Cavities……*Red*……

CHOL.....HDL.....LDL.....TRYGL.....
HOMEO:OPEN.....**MENT/CONST**.....**INTER**....
Pos Other Rem: .....
BODY TYPE - G…….A …….T…….P…….

T.C.M. DIAGNOSIS:-
.....
.....
.....

CLINIC USE:-

----------RATE----------STRENGTH---------- DEPTH.....
PULSES: Fast...Slow.. Full..Flood..Weak..V.Weak.. Super..Deep..
QI(Yang).... **QUALITY**
FLUIDS(Yin).....Choppy...Thin...Irreg...Tight...Wiry....Slipp....Other...

PULSES: Lu/Chest Sp/ST KidYang/SJ l Ht/PE Liv/G.B KidYin/UB
Strength:

TONGUE:-BODY:-.....

COLOUR:-.....

COATING:-.....
PAIN:- Neck…….Thoracic……..Lumbar……Sacrum…..Hip…….
Stretches…….. …….. …… …… ……
Shoulder Pain…… L……. R……..
I Goes to Chiro.....Physio..... **……**

DIFFERENTIAL WESTERN DIAGNOSIS :
.....
.....
.....

Lifestyle Changes:-