

SAVE
and send after filled in form
as an attachment to:
inquiry@biomedic.co.uk

BIOMEDIC ASSESSMENT FORM

Forenames: _____ **Surname:** _____ **Ref. no.:** _____

Date of birth: _____ **Today's date:** _____

Address: _____

_____ **Postcode:** _____

Telephone: _____ **Work:** _____ **Mobile:** _____

Occupation: _____ **E-mail:** _____

I am: *Single* *Married* *Divorced* *Separated* *Widowed* *With partner*

I live with: *Spouse* *Partner* *Friend* *Children* *Parents* *On my own*

I am currently: *Employed* *Unemployed* *Self Employed* *Retired*

My current Health concern is/are:

PREGNANCY/BIRTH

Did **your mother's pregnancy** progress to full term in a healthy manner, and if not, please explain:

Yes No

Was it followed by a normal vaginal delivery, and if not, please explain: Yes No

Have you been breastfed, and if yes, for how long? Yes, for _____ months No

MEDICAL HISTORY

Please list all **diseases, physical traumas and operations** that you have had and your **age** when they occurred:

	Age		Age
1. _____	_____	7. _____	_____
2. _____	_____	8. _____	_____
3. _____	_____	9. _____	_____
4. _____	_____	10. _____	_____
5. _____	_____	11. _____	_____
6. _____	_____	12. _____	_____

Please tick for the past or current **tendencies to frequently experience** the following:

Skin irritation	No	Yes, in the past	Yes, currently
Muscles and joint pain/aches	No	Yes, in the past	Yes, currently
Excessive sweating	No	Yes, in the past	Yes, currently
Indigestion	No	Yes, in the past	Yes, currently
Bloating/flatulence	No	Yes, in the past	Yes, currently
Constipation	No	Yes, in the past	Yes, currently
Diarrhoea	No	Yes, in the past	Yes, currently
Appetite oscillations	No	Yes, in the past	Yes, currently
Breathing difficulties	No	Yes, in the past	Yes, currently
Palpitation	No	Yes, in the past	Yes, currently
Frequent urination	No	Yes, in the past	Yes, currently
Tiredness	No	Yes, in the past	Yes, currently
Emotional difficulties	No	Yes, in the past	Yes, currently
Insomnia	No	Yes, in the past	Yes, currently
Frequent infections	No	Yes, in the past	Yes, currently
Others _____			

Females only

Age at onset **menstruation**? _____

Age at onset **menopause**? _____

Have you taken **oral contraceptive pills**? No Yes, how long? ____ months

Have you taken **Hormone Replacement Therapy (HRT)**? No Yes, how long? ____ months

Have you ever **experienced** any of the following? (Please tick)

Irregular periods	Uterine fibroids	Extra uterine pregnancy
Absence of period	Normal birth	Eclampsia
Metrorrhagia (haemorrhage)	Miscarriage	Diabetes during pregnancy
Infection in reproductive organs	Abortion	Placenta praevia
Ovarian cyst	Still birth	Infertility
Endometriosis	Premature birth	Cervical dysplasia

Family History

Please fill in the relevant medical details of **your family members**.

Diseases:			Family member:
Malignant Diseases:	Yes	No	_____
Congenital disease:	Yes	No	_____
High Blood Pressure:	Yes	No	_____
Heart disease:	Yes	No	_____
Blood disease:	Yes	No	_____
Lung disease:	Yes	No	_____
Stomach disease:	Yes	No	_____
Bowel disease:	Yes	No	_____
Liver/gall bladder disease:	Yes	No	_____
Kidney disease:	Yes	No	_____
Arthritis:	Yes	No	_____
Bone disease:	Yes	No	_____
Diabetes:	Yes	No	_____
Thyroid problem:	Yes	No	_____
Stroke:	Yes	No	_____
Multiple sclerosis:	Yes	No	_____
Epilepsy:	Yes	No	_____
Psychiatric disease (depression):	Yes	No	_____
Other, please specify:	_____		

Please give **name, dosage and frequency** of any current **medication** and when you started taking it:

Current medication:	Start date:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

If you are currently receiving/practicing any **alternative therapy(s)**, please specify:

List **any remedies, supplements, vitamins or herbs** you are taking **and when** you started taking it:

1. _____
2. _____
3. _____
4. _____
5. _____

DENTAL HISTORY

Have you got:

- | | | | |
|-------------------------------|----|-----|-------------------------|
| Bleeding gums? | No | Yes | |
| Amalgams (silver fillings)? | No | Yes | If yes, how many? _____ |
| Root canal procedure done? | No | Yes | If yes, how many? _____ |
| Paradentosis (receding gums)? | No | Yes | |

If any other dental work has been done, please list:

- _____ age: _____
- _____ age: _____
- _____ age: _____

ALLERGIES/SENSITIVITIES/DEFICIENCIES/TOXICITIES

Do you have any **medically confirmed** allergy? No Yes

If yes, please list: _____

Does **any** other substance trigger the experience of allergy-like symptoms? No Yes

If yes, please list: _____

Do you have any food cravings? No Yes

If yes, please list: _____

Have you been exposed to any of the following:

- | | | | | |
|---------------------------------|-----|----|-----------------|-----------------|
| Agricultural chemicals? | Yes | No | | |
| Industrial/workplace chemicals? | Yes | No | | |
| Cigarette smoking? | Yes | No | How much? _____ | How long? _____ |
| Alcohol use? | Yes | No | How much? _____ | How long? _____ |
| Recreational drugs? | Yes | No | How much? _____ | How long? _____ |

Other, please explain: _____

SELF- ASSESSMENT

Please list chronologically the **events** in your life that have had a **major psychological impact** on you and give your **age** when they occurred.

	Age		Age
1. _____	_____	7. _____	_____
2. _____	_____	8. _____	_____
3. _____	_____	9. _____	_____
4. _____	_____	10. _____	_____
5. _____	_____	11. _____	_____
6. _____	_____	12. _____	_____

My major positive and negative **characteristics** are (+) _____ (-) _____

My repetitive **dream** is: _____

My deepest **fear** is: _____

My **hobbies include**: _____

Other **relevant information** that you feel like conveying at this point:

Stress Management

Please **tick the most frequent trigger** of your stress:

Relationships with _____ *Money* _____ *Job security* _____

Other(s) – please specify: _____

Please **tick one or more of the physical signs** of your stress:

<i>Tiredness</i>	<i>Headaches</i>	<i>Neck ache</i>	<i>Backache</i>	<i>Chest pains</i>
<i>Palpitations</i>	<i>Digestive problems</i>	<i>Frequent urination</i>	<i>Loss of Libido</i>	<i>Period problems</i>
<i>Frequent infections</i>	<i>Sleep problems</i>	<i>Weight gain/loss</i>	<i>Excessive sweating</i>	

Other(s) – please specify: _____

Please **tick one or more of the psychological signs** of your stress:

<i>Moodiness</i>	<i>Apathy</i>	<i>Depression</i>	<i>Anxiety</i>	<i>Frustration</i>
<i>Indecision</i>	<i>Boredom</i>	<i>Guilt</i>	<i>Poor concentration</i>	
<i>Aggressiveness</i>	<i>Clumsiness</i>			

Other(s) – please specify: _____

Please **tick one or more of the behavioural signs** of your stress:

Being accident-prone

Addictions (alcohol, drugs, smoking, tea, coffee)

Withdrawal

Conflict making

Absenteeism

Other(s) – please specify: _____

Please draw **two pictures** that represent:

1. My Health condition

2. My ideal life

Name and contact telephone number of **your GP**: _____

Name and contact telephone number of **your dentist**: _____

How did you hear about us? _____

PAYMENT METHOD

Please note that **settlement of all accounts remains your responsibility** and not any third party. The fee of **£170 is payable after the treatment**.

Full fee will be charged for any cancelled or broken appointment **without prior notice of 24 hours**.

I confirm that I accept responsibility for all charges due for the Biomedic services provided.

Signature of patient/ parent/ guardian _____ Date: _____

THANK YOU

PRINT
and bring on appointment
to Biomedic doctor

WELCOME TO BIOMEDIC