

Profile Form 12

Date		Name	
Address		Address	
Tel (home/ office)		Mobile	
Email			
Date of Birth		Sex	Male / Female / Adult / Child
Occupation		Marital Status	Married/ Single
Weight (kgs)		Height (m)	
Family Doctor		Tel:	
Social Worker		Tel	

Medical History

Please tick either “yes” or “no” boxes

Please elaborate if you answer “yes” to any of the questions

	Yes	No
Have you been a patient in a hospital during the past 2 years?		
Have you been under the care of a physician during the past 2 years?		
Have you taken any kind of medicine or drugs during the past year?		
Are you allergic to penicillin or to any other drugs or medicine?		
Have you ever had any excessive bleeding requiring special treatment?		
Do you suffer from any illnesses?	If you answer “yes”, please use page 2 to elaborate.	
Have you ever had any other serious illnesses?		
(Women): Are you pregnant?	If “yes”, how many weeks?	
Do you wear specs or contact lens?		
Anything further you wish to tell?		

Consent:

I hereby give permission for you to contact my GP if it is for the betterment of my well being.

Sign: _____ **Date:** _____
Patient

Sign: _____ **Date:** _____
Parent/Guardian/ Social worker

Signature of parent if patient under 18 years.

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Please state N/A for EVERY field not applicable for the complete form, so that we know you have seen it and it does not apply to you

Current Illness	Medication	For how long?	Dosage

Main complaint(s): For each complaint, fill in order till last column which is "what time is it worse", then go to No2 and do same. You can either use *the options on page 4* or your own to describe your symptoms

	Complaint	For how long?	Where affected
1			
2			
3			
4			
5			

	What caused it	Type of: pain and direction (up etc),/cough/phlegm/ rash etc
1		
2		
3		
4		
5		

	What makes it worse	What makes it better
1		
2		
3		
4		
5		

	What time is it better, eg daytime etc	What time is it worse, eg evening etc
1		
2		
3		
4		
5		

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	<i>Feel free to use the options below to tell us what makes it better or worse.</i>
<i>Type of Pain</i>	burning/ pricking/ tearing/pulling/sharp/dull/bruised etc
<i>Type of Cough</i>	Chesty/ dry/ croupy/ tickling/ suffocative/ hoarse/ barking
<i>Type of Phlegm</i>	Stringy/ thick/ thin/ lumpy day/ night time white/ yellow/ green
<i>Better/Worse</i>	Lying down(left/right)/ standing/ walking/sitting/ Cold/ Warm/ humid Weather, Fresh/ Stuffy Air, Warm/ Cold drinks Noise/ Music/ Quiet/ Touch/ Rest/Motion/ Dark /Light/Alone/Company

Allergy, how long?	Part of Body	What triggers it	What makes it better?
Eczema			
Asthma			
Hay Fever			
Skin Allergy			
Urticaria (itching)			

Please indicate for how long you have had each or any of these allergies, if any.

Remember to type N/A where it does not apply to you.

Type of Person:

Complexion: Fair/ Dark,/ Pale./Rosy

Build: Stout/ Fat/ Slim/ Medium/ Muscular/ Bony/ Petite

Height: Short/ Tall/ Average

Skin: Flabby/ Tight skinned, / Dry Skin/ cracked/ Oily/ Normal

Body: hot / cold / Normal

Sweat (please state where): armpits/ forehead/ head hair/ nose/

You are generally better by : heat / cold

Most common type of pain: eg *burning/ pricking/ tearing/pulling/sharp/dull etc*

Do ailments come: suddenly/ suddenly with fever/ takes time for full effect

Are most of your ailments on the left or right side?

Are you left or right handed?

Others:

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<p>What does the patient like?</p>	<p>Food: Hot /Cold (temp), Food: Spicy/ Mild Food/ Sweet/salty/Crunchy Food: What food(s) do you crave for? Drinks: Hot /Cold Clothing: loose/ tight and why? Sweets – ice cream, chocolate, cakes Types of Drink: Milk/ Soft Drinks/ Tea/ Coffee / Alcohol Prefers: Indoor /Outdoor Prefers: Fresh/ Stuffy Air, Prefers:Dry / Wet/Gloomy/ Sunny Weather, Prefers: Cold/ Hot Air, Prefers to be: Alone or with Company , Can Sleep alone ? Y/ N, if No, why? Prefers: Walking/ Sleeping/ Sitting/ Standing Prefers: Playing Sports/ Watching TV/ Computer/ Doing Nothing/reading</p> <p>Others:</p>
<p>What does the patient dislike?</p>	<p>Food: Hot /Cold (temp), Food: Spicy/ Mild Food/ Sweet/salty/Crunchy Food: What food(s) are you averse to? Drinks: Hot /Cold Clothing: loose/ tight and why? Sweets – ice cream, chocolate, cakes Types of Drink: Milk/ Soft Drinks/ Tea/ Coffee / Alcohol Dislikes: Indoor /Outdoor Dislikes: Fresh/ Stuffy Air, Dislikes:Dry / Wet/Gloomy/ Sunny Weather, Dislikes: Cold/ Hot Air, Dislikes: to be: Alone or with Company , Dislikes sleeping alone ? Y/ N , if YES why? Prefers: Walking/ Sleeping/ Sitting/ Standing Prefers: Playing Sports/ Watching TV/ Computer/ Doing Nothing/reading Any Phobias: heights/ bugs/ snakes/ spiders/elevators/crowds/ dark/ dogs/ cats/ stuck in traffic/animals Explanation as to why the phobia and what happens:</p> <p>Others:</p>

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Mind: for each area that you answer “yes”, please describe why

Are you?	Yes/No	Explain why?
Restless		
Anxious/fearful		
Quarrelsome		
Depressed		
Suicidal		
Fearing death		
Irritable		
A worrier or carefree		
Worried about business		
Fearing the future		
Fearing poverty		
Fear Failure?		
Insecure		
Crying a lot/ tearful		
Wanting to cry but cannot		
Sometimes unable to think		
Someone who drops things easily		
Easily excited and emotional (delirium)		
Affected by the weather eg gloomy during stormy weather etc		
Jealous type		
Having a good memory		
Having a bad memory eg forgetful		
Difficulty learning		
Imagining things/ people etc		
Dreaming a lot (night or day)		Explain dream(s)
Sensitive or insensitive to peoples' remarks		
Stubborn		
Impatient		
The nervous type		

Please explain as much as you can your answers
Remember to type N/A where it does not apply to you

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General Attitude: for each area that you answer "yes", please describe why		
Are you?	Yes/ No	Explain why?
The giving/taking /Selfish (don't like to share)type	Give/Take/ Selfish	
Abusive – curse a lot		
Do you hit people or things		
Complaining a lot		
Having a compulsive behaviour		
Hyperactive –always wanting to do things		
Generally rude or polite		
One to get upset easily or don't care	Upset/don't care	
When is your best time in the day?	Morn/ aft/even/night	
Better at any specific time? Eg 11am etc	Yes/ No	
When is your worst time in the day?	Morn/ aft/even/night	
Worse at any specific time? Eg 4-8pm etc	Yes/ No	
Content with what you have or want more		
Impulsive – does things without thinking		
Wanting to do things in a hurry		
Do you feel time passes fast or slowly		
Do you think you can stay in one place or need to move continuously	Stay/ move	
Tidy / Tidy in order	T/ TO	
Messy		
How do you react to noise?		
How do you react to music?		
How do you react to company	Like/ don't like	
Happy with life		
Hot or cool temper		
Responsible or not		
Trusting or suspicious of people		
Tired Easily/ Tired all the time	TE/ TATT	
Confident		
Leader or a follower	Leader/ Follower	

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Sleep: hands behind head/ hands over head /right side/left side/ on back/on abdomen

Difficulty in going to sleep? If yes then explain.

Others:

Use for further description or comments

*please tell us what **YOU** would like to change about you.*

Please explain as much as you can your answers

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Any problems with:

	Problems	Type
Head		Forehead: high/widows peak/ wrinkles
Eyes		Black/ Brown/Blue/ Grey/ Green/ Unusual/ bulging/ penetrating/ smallish/ dreamy/ bags under/ beady/hollow look
Throat		Normal/ glands bulging
Ears		
Nose		Straight/ Hooked/ pointed/ short and fleshy/long and thin/ bony
Mouth		Wide/ small/ normal
Face		Angular/ Round/ longer than wide/ wrinkled/ hairy/ freckles/ moles/ wens/ bloated/ thin, bony/ young looking/ one cheek red other pale/ red cheeks
Lips		Thin/ Full/ full and well curved/ non-existent/ Thick/ thin, esp upper lip/ red

Please state any hobbies or habits you have: (eg Smoking, Playing football etc)

Please state how your childhood was:

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Family History

	Siblings	Maternal	Paternal	others
Diabetes				
Blood Pressure-high/low				
Obesity				
Cancer and type				
Other illnesses				

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For Office Use:

Medications and Recommendations:

No:	Date	Medication	Freq	Potency	Comments
1			1X/2X/3X a dy/wk/mth	30C, 200C	
2			1X/2X/3X a dy/wk/mth	30C, 200C	
3			1X/2X/3X a dy/wk/mth	30C, 200C	
4			1X/2X/3X a dy/wk/mth	30C, 200C	
5			1X/2X/3X a dy/wk/mth	30C, 200C	
6			1X/2X/3X a dy/wk/mth	30C, 200C	
7			1X/2X/3X a dy/wk/mth	30C, 200C	
8			1X/2X/3X a dy/wk/mth	30C, 200C	
9			1X/2X/3X a dy/wk/mth	30C, 200C	
10			1X/2X/3X a dy/wk/mth	30C, 200C	

Notes as a result of medication taken:

No:	Notes
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	