TheHolisticFIT

Consultation

View More Consultation Information at gillcarrie.com

Centre for Practitioner Health & Wellbeing

gillcarrie.com

TheHolisticFIT

CONSULTATION with GILL CARRIE

ALL INFORMATION GIVEN HERE IS KEPT STRICTLY CONFIDENTIAL

[do type in as much information as you need throughout - the boxes will expand to accommodate]

YOUR FULL NAME:

YOUR ADDRESS [inc. Post Code]:

YOUR TELEPHONE NO:

YOUR EMAIL:

YOUR GP & SURGERY:

YOUR SPECIALIST/S:

REASON FOR YOUR VISIT:
WHEN FIRST OCCURRED?

ANY OTHER CURRENT COMPLAINTS:
WHEN FIRST OCCURRED?

EXPECTED OUTCOME FROM 1st APPOINTMENT:
OVERALL, AIM + BY WHEN?

YOUR OCCUPATION:

YOUR DATE OF BIRTH:

1. CONSULTATION CONSENT: I GIVE MY CONSENT FOR TREATMENT WITH GILL CARRIE
Online Consultations, Health & Wellbeing Coaching & Support, Homeopathic Treatment incorporating Classical Homeopathy, Homeopathic Detox Therapy, Human Chemistry Integrated Therapy, Natural Balancing Therapy, Organ System Support, Orthomolecular Supplements.

SIGNED: **DATED:**

2.CONTACT CONSENT: I GIVE MY CONSENT FOR CONTACT BY GILL CARRIE
This incorporates via Email, Telephone, Zoom [or equivalent], Post. As part of the General Data Protection Regulation (GDPR), I, Gill Carrie is legally required to obtain written consent from all patients regarding how I contact you during treatment. I need to get written consent from you as the patient that allows me to contact you for and between appointments by either by email, telephone, zoom or post.

SIGNED: **DATED:**

YOUR CURRENT MEDICAL HISTORY – where you are now

CURRENT Please list all your CURRENT medication, prescriptions, over-the-counter medications, vitamins and other supplements that you are taking	
PREVIOUS Please list any PREVIOUS long-term prescriptions you have taken; eg. the birth control pills, blood pressure tablets, tranquillisers, HRT, etc	
VACCINATIONS Please list ALL vaccinations that you have had, and any severe reactions	
FILLINGS / IMPLANTS Please list any DENTAL fillings and implants that you have had, and any severe reactions Any other IMPLANTS?	
THERAPIES Please give details of other therapies that you are currently using	
ALLERGIES & INTOLERANCES Please list ALL allergies and intolerances that you have and / or had	
TESTS Please list ANY tests that you have recently had eg. blood, urine, hair, etc **TEST RESULTS ATTACHED YES / NO**	

YOUR FAMILY MEDICAL HISTORY – background to you

This Information is about the health of your blood relatives, whether they are still alive or have passed, and is of immense value to a Homeopath.

Don't be offended with any of the information requested, their words or how they're put - they're only descriptions for understanding you, holistically – and may relate to any symptoms presenting at any given time.

Please give key information about any genetic conditions and diseases, medications, operations, history of any alcohol and/or drug addiction, abusive incest, assault, epilepsy, behavioural problems or unusual conditions or problems. Please give cause of death and age of your relative/s, if known.

MATERNAL: YOUR MOTHER'S SIDE OF THE FAMILY	
Your MOTHER - Before your conception - During pregnancy with you - Throughout their life - Currently	
Your Grandmother	
Your Grandfather	
Your Aunts / Uncles	
Your Cousins	

PATERNAL: YOUR FATHER'S SIDE OF THE FAMILY	
Your FATHER - Before your conception - During pregnancy of you - Throughout their life - Currently	
Your Grandmother	
Your Grandfather	
Your Aunts / Uncles	
Your Cousins	

YOUR FAMILY: YOUR SIBLINGS & YOUR CHILDREN	
Your SIBLINGS	
Your CHILDREN	

YOUR EARLY HISTORY - YOUR TIMELINE - a powerful tool, giving 90% information required

	DESCRIPTION	**MEDICATION / OTHER**
Your Family history	*(detailed above)*	*(detailed above)*
Your Conception - Circumstances - Was the baby wanted - Miscarriage or abortion before - Alcohol, drugs, hormones/IVF/pill/coil, vaccinations, medications - Stress, sadness		
Pregnancy (of You) - Medications, food (-errors), artificial sweeteners - Contraction stimulator (TENS) - Vaccinations - Blood loss - Acceptance of the pregnancy by parents - Mother's emotional state		
Your Delivery - Natural or otherwise - Anaesthesia/epidural - Induced - Position of baby - Placenta condition - APGAR score - Rhesus injection (0 negative)		
Your Birth Weight / Length / Height plus **Hair / Face / Skin / Nails**		
Breastfeeding (of You) - How long for - Exclusively - Medications used by mother		
Your Vaccinations - Which and when (year) - Tropical vaccinations and/or other - Reactions		
Your First Year - Medication (eg. antibiotics, aspirin, paracetamol/acetaminophen, corticosteroids, etc) - Surgical procedures - Eating habits/problems		
Your First 4 Years - Medication (eg. antibiotics, aspirin, paracetamol/acetaminophen, corticosteroids) - Surgical procedures - Eating habits/problems		

YOUR MEDICAL HISTORY FROM 5 YEARS OF AGE – a great tool to keep building

YEAR eg. SPECIFY AGE/S	**DESCRIPTION** eg. MEASLES, MUMPS, CHICKEN POX , GERMAN MEASLES, SCARLET FEVER, GLANDULAR FEVER, RHEUMATIC FEVER, TONSILLITIS, DIPHTHERIA, RECURRENT COLDS, EAR PROBLEMS, WHOOPING COUGH, TUBERCULOSIS. eg. SKIN PROBLEMS, ALLERGIES, WARTS, MOLES, RINGWORM, CYSTS. eg. SURGERY, ACCIDENTS, HOSPITILISATIONS.	**MEDICATION / OTHER** eg. PRESCRIPTIONS, OVER-THE-COUNTER MEDICATIONS, VITAMINS, SUPPLEMENTS, VACCINATIONS, TESTS, THERAPIES,	**BODILY / PHYSICAL DETAILS** eg. WEIGHT, HEIGHT, BUILD, HAIR, FACE, SKIN, NAILS, TEETH – look & changes	**MAJOR LIVE EVENTS** eg. MENTAL, EMOTIONAL, SPIRITUAL EVENTS – that affected you
5-10				
10-15				
15-20				
20-30				
30-40				
40-50				
50-60				
60-70				
70-80				
80-90				
90-100				
100+				

YOUR JOURNAL

Your space for journaling …

- any changes
- new insights
- additional health & wellbeing aims / goals
- coaching insights
- questions arising
- add more pages

… to build and please bring to our consultations

YOUR JOURNAL for your Symptom Awareness, Management and Changes – Overview

A great sheet for bringing awareness to and for recording any changes.
Ideally for bringing to all appointments / after remedy prescriptions / courses.

AWARENESS	SYMPTOM/S	CHANGES
MIND / EMOTIONS		
MOODS / MEMORY		
ENERGY		
ACTIVITY - EXERCISE / STUDY / WORK		
TEMPERATURE / FEVER / PERSPIRATION + METABOLISM		
WEATHER / ENVIRONMENT		
DIET / APPETITE / THIRST		
ALCOHOL / SMOKING / DRUGS		
SLEEP / DREAMS		
FEARS / ANXIETIES / PHOBIAS / HABITS		
STRESS / STRESSORS		
LIKES / DISLIKES		
SPECIFIC PHYSICAL SYMPTOMS		
MEDICATIONS / OTC MEDICATIONS		
VACCINATIONS		
ALLERGIES / INTOLERANCES / REACTIONS		
THERAPIES		
SUPPLEMENTS		
Any other observations …		