YOUR ROOT to SOUL JOURNAL

PART ONE

YOUR FIRST CONSULTATION with GILL CARRIE

'your story, your energy, your body – we meet there'

Gill Carrie

ROOT to SOUL

ROOT

Your physical wellbeing foundation.
We explore your body's patterns, support detoxification and restore balance.
Root provides practical stabilising solutions that strengthen your resilience and wellbeing.

FLOW

Your mental and emotional landscape.
We align your thoughts, emotions and energy to restore clarity, focus and equilibrium.
***Flow* nurtures balance, steadiness and life** engagement, supporting where most needed.

SOUL

Your deeper layers of experience.
We integrate lived patterns, familial, ancestral, archetypal influences, individually tailored to you.
Soul engages the deeper currents shaping your health, relationships and personal growth.

Root stabilises. Flow restores. Soul deepens.
A precise, layered and personal approach – **grounded in Integrative Homeopathy**, delivering tailored solutions that restore, balance and transform your health and well-being.

GILL CARRIE

Founder and Practitioner of FIND
… a different kind of Wellbeing Salon.

An integrative Homeopathic Practice, Clinic and Salon
specialising in Hair, Hormones, Health and Homeopathy

Grounded in Classical Homeopathy, Homeopathic Detox Therapy, Human Chemistry and decades as a Salon Owner, Educator, Lecturer and Collaborator – Gill brings a rare depth of care.

Here, you are met wholly – your story, your energy, your body.

Your Root to Soul Journal is where we begin – an intimate portrait of your health, capturing the details, patterns, experiences and changes that shape your individual story and inform each consultation.

BOOK YOUR FIRST CONSULTATION

RSHom Society of Homeopaths
BSc (Hons) Homeopathy & Licentiate Middlesex University and Centre for Homeopathic Education, London
Human Chemistry Integrated Therapy Netherlands

YOUR INFORMATION & CONSENT

PLEASE COMPLETE with CONCISE KEY INFORMATION, SIGN & RETURN BEFORE YOUR FIRST CONSULTATION - WE CAN EXPAND ON, WHEN REQUIRED. ALL INFORMATION IS STRICTLY CONFIDENTIAL.

YOUR FULL NAME:

YOUR ADDRESS [inc. Post Code]:

YOUR TELEPHONE NO:

YOUR EMAIL:

YOUR GP & SURGERY:

YOUR SPECIALIST/S:

REASON FOR YOUR CONSULTATION:

WHEN FIRST OCCURRED?

ANY OTHER CURRENT COMPLAINTS:

WHEN FIRST OCCURRED?

EXPECTED OUTCOME FROM 1st CONSULTATION:

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.

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:**

REASON FOR YOUR CONSULTATION - MORE INFORMATION

YOUR MAIN CONCERN/COMPLAINT	
CURRENT SYMPTOMS Inc. the precise location, and any other specific symptoms - even if rare, unusual or feel peculiar	
MEDICATIONS / THERAPIES etc. TAKEN FOR	
ANY CONTRIBUTING MAINTAINING CAUSES?	
ANY OTHER CURRENT COMPLAINTS ? *List any concomitant / accompanying symptoms*	
ANY OTHER CONCERNS?	
FEELING OF 'I'VE NEVER FELLT GOOD SINCE .....? *Can be something small something major*	

YOUR CURRENT MEDICAL HISTORY

CURRENT Please list all your CURRENT medication, prescriptions, over-the-counter medications [OTC], vitamins and other supplements that you are taking – plus any reactions/ side- effects/sensitivities from	
PREVIOUS Please list any PREVIOUS long-term prescriptions you have taken, e.g. 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 PREVIOUS MEDICAL HISTORY

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 – plus any reactions / side-effects from	**BODILY / PHYSICAL DETAILS** eg. WEIGHT, HEIGHT, BUILD, HAIR, FACE, SKIN, NAILS, TEETH – look & changes	**MAJOR LIFE EVENTS / TRAUMAS** eg. MENTAL, EMOTIONAL, SPIRITUAL EVENTS or TRAUMAS – that affected you
0-5				
5-10				
10-15				
15-20				
20-30				
30-40				
40-50				
50-60				
60-70				
70-80				
80-90				
90+				

YOUR FAMILY MEDICAL HISTORY

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 with 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

[If you can, complete as much as possible}	**DESCRIPTION**	**MEDICATION / OTHER**
Your Conception - Circumstances - Wanted / Unexpected - Surrogacy - 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 mental & emotional state		
Your Delivery - Natural or otherwise - Anaesthesia/epidural - Induced - Position of baby (you) - Placenta condition - APGAR score - Rhesus injection (0 negative)		
Your Birth Weight / Length / Height plus Hair / Face / Skin / Nails		
Breastfeeding - 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		