**ASSESSMENT SHEET** Patient ID……………………. (Client to complete).

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| Presenting Conditions and medical diagnosis (if any) |
| How does this affect your day to day activities/hobbies  |
| What aggravates your symptoms and what gives you relief |
| How does this condition affect you generally (sleeping pattern/anxiety/stress levels etc… |
| Clients expectation of treatment:-  |
| **Treatment Preference**:- Acupuncture; Auricular Acupuncture; Bowen Therapy; Bowen Lymph work; MSTR Scar work; B12 injection. All leaflets can be down loaded from [www.lesleytgreen.co.uk](http://www.lesleytgreen.co.uk) (Can be decided following consultation)  |

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| **MEDICAL CHECK LIST:– COVID 19**1: Have you had the recent onset of a new continuous cough?  YES NO 2: Do you have a high temperature?  YES NO 3: Have you noticed any loss or change in your normal sense of taste or sense of smell  YES NO 4: Have you noticed a new rash on your arms or legs  YES NO 5: Have you been abroad in the last 14 days?  YES NO 6: Does anyone in your household have symptoms of Corona virus?  YES NO  |
| Current Medication  |
| List and date previous operations |

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| **MEDICAL HEALTH CHECK LIST**EPILEPSY YES/ NO HEART DISEASE / BP YES / NO CURRENTLY PREGNANT YES/ NO FRACTURES YES / NODIGESTIVE YES/ NO RESPIRATORY YES / NO GENITO/URINARY YES / NO CIRCULATORY YES / NO ALLERGIES YES / NO WHIPLASH INJURY YES/ NOOTHER HEALTH ISSUES |