**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 / NO  DIGESTIVE YES/ NO  RESPIRATORY YES / NO  GENITO/URINARY YES / NO  CIRCULATORY YES / NO  ALLERGIES YES / NO  WHIPLASH INJURY YES/ NO  OTHER HEALTH ISSUES |