Natural Connections Healthcare

Consultations Leading to Treating the Causes not the symptoms!

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PATIENT ASSESSMENT FORM

Dear potential patient,

This questionnaire is important for Dr. Wilson to get a good 'picture' of your health issues. Please answer the questions as fully as you can and add anything else that you think is important or meaningful. Please note that your medical files will be kept strictly confidential and only Dr. Wilson will have access to this form. Once you have completed the form, please return it via email to the encrypted server: **Hush@dcnn.pro.**

Dr. Wilson will email you back with further instructions based on the information given below.

Personal Details

Date Form is Completed: **Surname:** **First name(s):** **Title:** (Mr, Miss, Mrs, Dr.): **Date of Birth** (Day, Month, Year): **Gender:**	**Height:** **Weight:** **Occupation:** **Marital Status:** **Number of Children:**

Full Address:
City: **Postal / Zip Code:** **Country:**
Phone: (include international dialing code): **Phone (mobile):**

Fax: **Email:**

Medical Details

Who referred you?

Your Doctor(s)'name, specialty, and contact details:

Your Dentist's name and contact details:

Medical History

What are your current symptoms?

How long have you been suffering from the above symptoms?

Does anything make your symptoms worse / better?

Has your condition been given a medical name / diagnosis? If so, what?

Please describe any pain that you have now, and its location:

Please list all your medications, including vitamins, minerals, herbs, and homeopathics:

Drug Name	*Dose*	*Frequency*	*Duration*	*Any Benefits*	*Any Side-Effects*

Do you have any known allergies to drugs, foods, animals, materials, etc?

Substance Name	*Reaction You Had*

Please list any other conditions you suffer/have suffered from, e.g. asthma, high blood pressure, diabetes, epilepsy, childhood illnesses etc:

Please list any previous surgical operations, together with dates (include any accidents/fractures/trauma):

Blood type: A / B / AB / O

Have you ever had a blood transfusion? If so, when and why?

Does anyone else in your family or in your workplace suffer from the same symptoms/disease as you?

Past Medical Factors

Please list your all your immunizations/vaccinations, together with dates:

Have you ever taken antibiotics? If so, how many times?
For what reason?

Are / were you a smoker? **If so, what do / did you smoke?**
How many per day? **How many years?**
If you quit, when?

Do you / have you ever tried recreational drugs?
If so, what? **Frequency?** **How many years?**

Do you have any scars on any part of your body, and if so, where exactly?

Dental History

Do you have metal dental fillings? If so, how many?

Have you had any removed? If so, how many and when?

Did you follow a detoxification protocol with / after their removal? If so, what did it involve?

Do you have root canals? If so, how many?

Do you have crowns or other metals in your mouth? If so, what?

Have you had any teeth extracted? (Such as wisdom teeth.)

Other dental conditions or concerns:

Family History

Where are you in the birth order? __Firstborn; __Second; __Third; _____

Before you were there any: __Stillborn; __Miscarriage: __Abortions; how many?_____

Major medical conditions in family members:

Allergies in family members:

Alcoholism in family members:

Addictions in family members:

Suicide in family members:

Depression in family members:

Other:

Nutrition

Did/do you drink coffee? How many cups per day? How many years?
If you quit, when?

Did/do you drink black tea? How many cups per day? How many years?
If you quit, when?

Did/do you drink carbonated beverages, e.g. coke, 7Up, tango etc…? How many years?
Do you drink "Diet" drinks, e.g. Diet Coke?
If you quit, when?

Do you consume alcohol? If so, how much and how often?
What kind of alcohol?

Do you eat large or regular amounts of chocolate and sweets?

What is your water source? How much do you drink (cups / litres)?

Do you eat *organic* fruits and vegetables?

Write down everything you eat and drink over a typical three-day period.
(Include condiments, snacks, sweeteners, drinks etc.)

DAY ONE:

Breakfast:

Lunch:

Dinner:

Snacks:

DAY TWO:

Breakfast:

Lunch:

Dinner:

Snacks:

DAY THREE:

Breakfast:

Lunch:

Dinner:

Snacks:

Are you happy with your eating habits?

Exercise

Do you have movement limitations?

What types of body movement do you do?

Do you exercise? If so, what kind of exercise, and how often?

Sleep

How many hours do you sleep at night?

Do you sleep in a totally dark room? Nightlight? Lighted Clock?

Is there noise around you? Do you snore? Is there fresh air in your room?

Describe the quality of your sleep:

Emotions

Are you happy where you live now? If not, why?

Have you always lived there?
If not, briefly mention towns/cities/countries you have lived in the past (since childhood):

Is your occupation stressful? If so, why?

How is your relationship with your co-workers?

How is your relationship with friends and family? Any problems?

Are there any stressful circumstances in your life right now?

Are you traveling extensively?

Environment

Do you have any pets?

Do or have you used aluminum cookware?

Do or have you used spray deodorants or antiperspirants? If so, what kind?

Do or have you used hair colour dyes or bleaches? If so, what kind?

What cosmetics do you use regularly?

Do you use antacids?

Are you now on or have you ever taken birth control pills? How many years?

Are you now or have you ever been on hormone replacement therapy (HRT)? If so, for how long?

What kind of heating/air-conditioning do you have in your home?

What kind of heating/air-conditioning do you have at work?

Has there been any kind of remodeling/construction in your home recently?

Do you live or work near any farms, large agricultural areas, nuclear reactors or military bases? If so, what kind and how many miles away?

Have you ever been exposed to toxins of any kind? What?

Are there any high-tension lines or step-down transformers near your home or work?

Tick any of the following that you use:

Micro-wave oven ***( )***
Electric blanket ***( )***
Water bed ***( )***
Fluorescent lights ***( )***
Computer ***( ) – if so, how many hours per day?***
Television ***( ) – if so, how many hours per day?***
Mobile/cell phone ***( ) – if so, how many hours per day?***

Is there anything else you wish to add, which you think may be relevant?

Thank you once again for taking the time to complete this important questionnaire. If you have had any problems completing this, or if you have any questions whatsoever, please do not hesitate to contact us.

Please email your completed questionnaire as soon as possible, to aid in your consultation.

Telephone: (+00-1) 202-657-5732

Email: dr.wilson.online@gmail.com

PLEASE ENSURE THAT YOU KEEP A COPY OF THIS QUESTIONNAIRE, IN CASE YOUR LETTER DOES NOT REACH US