Dorothy Watt
HOLISTIC WELLNESS ADVOCATE

First Visit Questionnaire – Adult

Please complete this form carefully and thoroughly. This information will be kept confidential.

Name	
Date of birth	
Address	
Postcode	
Home telephone	
Mobile telephone	
Email address	
Referred by	Family / Friend / G.P. / Advert / Other – please specify
General Practitioner	
General Practitioner address	
General Practitioner telephone	

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Consent and acceptance of terms and conditions

I understand that homeopathy is an alternative approach to health that involves me taking full responsibility for my health. I will not hold Dorothy Watt liable in any way for my health issues and understand they accept no liability.

I understand I should only withdraw from medication after consultation with my GP and under their supervision. I must contact my GP or Casualty Department for medical emergencies.

I understand that a cancellation charge of the full fee will apply if I fail to give at least 24 hours' notice before my appointment or for non-attendance.

Accepting the above provisos, I request homeopathic treatment from Dorothy Watt.

Signature		Date	

Privacy Statement and Acceptance Form

Please tick to show your acceptance

- ☐ Dorothy Watt uses my personal information to further her understanding of my reasons for consulting her, and to prescribe remedies and other therapies
- ☐ Dorothy Watt will ask my permission before sharing my personal information with anyone else, unless she is legally required to do so
- ☐ Dorothy Watt will communicate with me by email, text, phone and post

I understand that I can, at any time, request that my personal information not be used for these purposes by contacting:

Dorothy Watt, 9 Buckingham Street, Oxford, OX1 4LH

hello@dorothywatt.com

While I remain a client of Dorothy Watt (and for a minimum of seven years thereafter), I accept that my personal information will be used for the purposes detailed above.

Signature		Date	

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Please describe the condition(s) about which you would like to consult me:

Present treatment

Please list any current medication including vitamins, supplements etc…

Please list any other current treatment and complimentary therapies:

Medical history

Please list all major diseases, accidents, hospitalisations, medical treatments and traumas in chronological order. Include childhood diseases and any long-term prescriptions such as birth control pill, blood pressure tablets, HRT, tranquillisers, sleeping pills etc. If you have any information about your birth or your mother's pregnancy or labour, please include that as well.

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Pre-birth: Any emotional / physical problems experienced by your mother during her pregnancy			
Birth: Details of your mother's labour, pain relief, interventions.			
	Age	Condition	Treatment
Childhood Illnesses:			
Accidents: Note serious ones and those which you feel are important			
Surgical procedures / major dental works: Was anaesthesia used?			
Use of drugs: Heavy / prolonged use - recreational or prescribed.			
Severe viral infections: e.g. meningitis, glandular fever etc			
Shocks / Trauma: Anything which may have affected mental/emotional /physical wellbeing.			

Vaccinations: Please list all vaccinations, with dates, and any reactions

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Allergies: Please list any allergies, past and/or present with age it started / stopped.

Family medical history

List all diseases of blood relations, including cause and age of death where applicable. If possible, **please include any long-term prescriptions which your mother or father were taking before your birth (e.g. contraceptive pill, recreational drugs)**. Please also indicate where there may be a history of alcoholism, drug addiction, behavioural problems, birth defects, disabilities or any particular condition or problem. This information is genuinely of value and will be kept confidential.

Mother	Father
Grandmother	Grandmother
Grandfather	Grandfather
Aunts	Aunts
Uncles	Uncles
Cousins	Cousins
Your brothers and sisters	
Your children	

Please continue overleaf with any other information you think might be useful.