

New Patient Referral Form

This document is strictly private and confidential

Information is required for your safety and to benefit your health and welfare.

The following details will be treated with the **strictest confidence.**

Questions, for which you do not wish to reply, leave blank and they will be discussed during initial consultation, please.

A **£25 - 1hour** pre-screening - will be conducted prior to scheduling the initial assessment/consultation session in order to determine the appropriateness of the referral, question the likelihood of fit for my services, and to answer your questions. To get started, complete this Form.

PLEASE PRINT and bring it with you at first consultation or email it to

abm@mpsym.co.uk

First Name (only) _____ / Gender Male Female

D.O.B. ____/____/____

Your Home Address _____

Post Code _____ Mobile telephone number _____

Email address _____

Occupation _____

Marital Status _____ If Married, since _____

Children: how many _____ age/gender _____

Name of GP (will not be contacted) _____

GP Address _____

Post Code _____ telephone number _____

Your Height

cm or feet

Your Weight

kg/or Lbs

BMI (Office use) < 18.5 / 24.9 / 29.9 / > 30

Blood Pressure

Religion

Are you strict believer/follower

YES

NO

MEDICATIONS

Please list all medications that you are currently taking (or within last 6 years)

	Name of medication	Dosage	How often
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			

ARE YOU CURRENTLY TAKING ANY NON PRESCRIPTION DRUGS, MEDICATIONS OR SUBSTANCES? (If taken any in the past, please enter year)

SOLVENTS	YES	NO	When last taken?
OPIATES	YES	NO	When last taken?
STIMULANTS	YES	NO	When last taken?
HALLUCINOGENS	YES	NO	When last taken?
CANNABIS	YES	NO	When last taken?
AMPHETAMINS	YES	NO	When last taken?

Do you smoke?	YES	NO
If Yes, how many ?	Cigars	Cigarettes
Do you drink alcohol?	YES	NO
Do you know how many units?	Wine	
	Spirit	
	Beer	
	Other	
Do you drink socially?	YES	NO
Binge drinking	YES	NO

Ability to relax?	Poor
	Average
	High

Do you take exercise?	None
	Occasional
	Irregular
	Regular

WOMEN ONLY

Are you pregnant?	YES	NO
Have you recently experienced a		
miscarriage	YES	NO
termination	YES	NO
Do you experience irregular periods?	YES	NO
PMT?	YES	NO
MENOPAUSE?	YES	NO
Contraception Patch	YES	Since
IUS	YES	Since
IUD	YES	Since
LARC	YES	Since
Diaphragm/caps	YES	Since
Other	YES	Since

DO YOU SUFFER FROM ANY OF THE FOLLOWING?

Acne	YES	NO
ADHD	YES	NO
Anxiety	YES	NO
Arthritis	YES	NO
Back Problems	YES	NO
Bloating	YES	NO
Cancer	YES	NO
Cellulite	YES	NO
Colds	YES	NO
Constipation	YES	NO
Cystitis	YES	NO
Depression	YES	NO
Diabetes	YES	NO

Diarrhoea	YES	NO
Digestive Problems	YES	NO
Dizziness	YES	NO
Ear Problems	YES	NO
Eating Disorder	YES	NO
Epilepsy	YES	NO
Eye Problems	YES	NO
Fluid retention	YES	NO
Gall bladder Problems	YES	NO
Headaches	YES	NO
Hearth Problems	YES	NO
High Blood pressure	YES	NO
Insomnia	YES	NO
Kidney Problems	YES	NO
Liver Problems	YES	NO
Loss of appetite	YES	NO
Low blood pressure	YES	NO
Migraine	YES	NO
Neck Problems	YES	NO
Phobias	YES	NO
Poor blood circulation	YES	NO
Rheumatism	YES	NO
Low Self-esteem	YES	NO
Sickness	YES	NO
Sinuses	YES	NO
Stiff Joints	YES	NO
Stomach Problems	YES	NO
Stress	YES	NO
Varicose Veins	YES	NO

FOOD

Do you eat regular meals?

YES

NO

Do you eat in a hurry?

YES

NO

Do you have a healthy balance diet?

YES

NO

How much of each of these does your diet contain?

Amount x day **or** x week

Fresh Fruit

Canned Fruit

Fresh Vegetables

Frozen Vegetables

Fat (oils - lard - butter)

Fresh Fish

Frozen Fish

Fresh Meat

Frozen Meat

Rice/Pasta

Pizza

Ready made meals

Grain(s)

Milk

Cheese

Eggs

Biscuits/Cakes

Sweets

Crisps

Chocolate

Water
Tea
Coffee
Soft Drinks

- Do you eat outside meals? **YES** **NO**
What?

- Do you tend to suffer from indigestion? **YES** **NO**

How often do you eat the following?

Per Week

McDonalds

KFC

Pub

Kebab

Fish and Chips

Pizza

Other (specify)

IS THERE ANYTHING ELSE THAT YOU WOULD LIKE TO MENTION/ADD?

WHAT DO YOU FEEL THERAPY WILL DO FOR YOU?

CONSENT FORM

This form should be used for clients, over 16, who can consent to engage in Therapy. I declare that the information given is correct and, as far as I am aware, I can undertake Therapy and I am willing and happy to proceed.

Base fee for therapy is **£65 per 50-minutes** time/session

I have read Terms and Conditions – www.mpsym.co.uk

I have read Charges and Payments – www.mpsym.co.uk

I (please, print full name) _____
consent to receiving
therapy

Client Signature _____

Practitioner's name Alfredo Procaccini

Practitioner's signature _____

Date _____/_____/_____

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