# 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 **£18 - 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**

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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 TAKING ANY SUPPLEMENTS OR VITAMINS?**

| Name of Supplement or Vitamin | Dosage | How Often |
|---|---|---|
| | | |
| | | |
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**HAVE YOU EVER HAD ANY SURGICAL INTERVENTION?**

| Type of intervention/operation | When |
|---|---|
| | |
| | |
| | |

**DO YOU SUFFER FROM ALLERGIES YES / NO**

If YES, please give short descriptions to which one(s) and how often (when)

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|---|
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**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 |

**ARE YOU AWARE OF ANY, OUT OF THE ORDINARY, BLOOD RESULTS?** (i.e. Creatinine, Uric acid, White blood cells, PSA, Cholesterol etc.) IF YES, please provide details (should you have latest blood test results, please bring them with you).

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Hobbies? _____

_____

_____

Interests? _____

_____

_____

| | | |
|---|---|---|
| Sleep Patterns? | GOOD | POOR |
| On average, how many hours? | | |
| Do you have daylight in your workplace? | YES | NO |

On a scale of 1-100 (100 being the most stressful), how stressed are you at the moment

| | |
|---|---|
| HOME | WORK |

**ALLERGIES TO FOOD/ RESTRICTIONS TO FOOD YOU CANNOT EAT**

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|---|
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## 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?

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- 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?**

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**WHAT DO YOU FEEL THERAPY WILL DO FOR YOU?**

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**HOW WOULD YOU DESCRIBE YOUR CURRENT PRESENTING ISSUES/SYMPTOMS?**

**GOALS / AIMS / EXPECTATIONS / OUTCOMES**

**HAVE YOU HAD THERAPY/COUNSELLING/PERSONAL COACHING BEFORE? IF YES, PLEASE DESCRIBE**

**ANY OTHER COMMENTS?**

## 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** _____/_____/_____

**For Office Use Only**