

ELECTRO LYMPHATIC THERAPY

REGISTRATION

PERSONAL DETAILS

First appointment date: ___ / ___ / ___

Surname:	Forenames:
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Title: Mr /Mrs /Ms /Miss/Other

Date of birth: ___ / ___ / ___

Age:

Address:	
	Postcode:
Telephone (H):	(Mobile)
E-mail:	

Referred by: _____

Address: _____

Telephone: _____

Are you a patient of Dr Daya?

In the past Currently In the future (*I have made an appointment*) No

What is your preferred form of contact for reminders and messages? (please tick)

By letter By email (*address*) _____

*By landline *By mobile *Do you give us permission to leave a full message on this number
(*stating the clinic name and a brief message on why we are calling you*)?

Yes

No

PATIENT DISCLOSURE

- I understand that if I have found breast lumps, cysts or any other symptoms on the breast or other parts of the body; they should be thoroughly checked by a medical Doctor. If necessary they may need to be correlated by further clinical tests before undergoing ELT treatment.
- I understand that if I have cancer or I am undergoing treatment for cancer it is my responsibility to seek advice from my consulting doctor before I receive ELT treatments.
- I understand that I cannot undergo ELT treatment if:-
 - I am pregnant (*unless referred by consulting Doctor*)
 - I have an electrical implant support system on my body (*including a Pacemaker*)
 - I have had recent surgery (*within the last 4 weeks*)

By signing below, I certify that I have read and understand the statements above and consent to the treatment

Signature _____

Today's date _____

ELECTRO LYMPHATIC THERAPY (ELT) QUESTIONNAIRE

A. PAST MEDICAL HISTORY

Please list in chronological order all major diagnosis, conditions, operations, other major treatments, serious accidents or injuries, special tests, x-rays, etc.

Year and month	Condition
_____	_____
_____	_____
_____	_____
_____	_____

Please list any **prescribed medication** or **nutritional supplements** you are currently taking:

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Please give details of any allergies you may have:

Have you had chemotherapy / radiotherapy?

Have you undergone any surgery in the last 4 weeks?

Do you have an electrical implant or pace maker? YES / NO

Are there any other details you feel should be mentioned about your health? If YES please state:

B. DIETARY AND LIFESTYLE

Do you smoke? If YES state if cigarettes, etc. and how many per day:

Do you drink? If YES state daily consumption of alcohol:

Do you drink tea and/or coffee? If YES please complete questions below:

Cups of tea per day:

Cups of coffee per day:

- Do you take sugar YES / NO or artificial sweeteners YES / NO with your beverage?

4. Do you or have you used drugs recreationally? YES / NO

5. Please state the approximate times and what you normally eat at the following meals:

<u>Breakfast (Time _____)</u>	<u>Lunch (Time _____)</u>	<u>Dinner (Time _____)</u>

7. How much water do you drink per day?

8. Do you crave any foods? *If YES give details:*

The next section should be completed by women only

C. MENSTRUATION:

If menopausal, please also complete this stating what your menstrual cycles were like.

1. Age at onset: _____
2. Are your periods regular? YES / NO Please give details _____
3. Length of cycle (in days) _____
4. Are your periods heavy/light/medium/other? (*Please circle*)
5. Do you suffer any pre-menstrual symptoms? YES / NO

D. MENOPAUSE:

1. Age of menopause? 4. Are you on hormone replacement therapy? YES / NO
2. Have you had a hysterectomy? YES / NO If YES state at what age and reasons: _____

E. CONTRACEPTION:

1. Are you currently sexually active? YES / NO If YES what form of contraception do you currently use?
2. Have you ever taken the Pill? YES / NO If YES please state approx. when and for how long?

F. PREGNANCY:

1. Are you pregnant? YES / NO If YES how many weeks pregnant are you?
2. Have you given birth in the last 4 weeks YES / NO If YES was it a natural birth or by caesarean section?
3. Are you currently or recently breast feeding? If recent, when did you stop?

G. ADDITIONAL INFORMATION:

1. Have you ever had an abnormal mammogram or breast biopsy? YES / NO If yes please give date _____
2. Have you had any abnormal smear results in the past? If YES please give details and treatment:
3. Do you have breast implants? YES / NO If yes please give details _____
4. Have you had Thermal Imaging here at the Wholistic Medical Centre? YES / NO If yes please give date _____

Name _____

Sign: _____

Date: ___/___/___

TREATMENT HISTORY

(This sheet is for Practitioner use only)

Date	Region of Interest	Comments/Progress
		Notes/1 st treatment:
		Since last treatment: After today's treatment:
		Since last treatment: After today's treatment:
		Since last treatment: After today's treatment:
		Since last treatment: After today's treatment:
		Since last treatment: After today's treatment: