

# 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?

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

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

**Breakfast**

**Lunch**

**Dinner**

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How much water do you drink per day? \_\_\_\_\_

Do you crave any foods? If YES give details:

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**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 / regular / irregular? (*Please circle* )
5. Do you suffer any pre-menstrual symptoms? YES / NO

**D. MENOPAUSE:**

1. Age of menopause? \_\_\_\_\_ 2. Are you on hormone replacement therapy? YES / NO
3. 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: \_\_\_/\_\_\_/\_\_\_