Dr Herman Spies

Patient Details:

Surname: _____ Title: _____. Home Language: _____.

Full Names 1. Main Member: _____ ID No.: _____.
2. Spouse: _____ ID No.: _____.
3. Child: _____ Birth Date: _____.
4. Child:_____ Birth Date: _____.
5. Child:_____ Birth Date: _____.
6. Child:_____ Birth Date: _____.

Medical Aid Details:

Medical Aid Name: _____. Address: _____
Medical Aid Option: _____. _____
Medical Aid Number: _____. _____
Date Issued: _____. _____.

Addresses and Telephone Numbers:

Home Address: _____ Home Tel. No.: _____.
_____ Cell. No. Main Member: _____.
_____. Cell. No. Spouse: _____.
Postal Address: _____ eMail Main Member: _____.
_____ eMail Spouse: _____.
_____.
Work Name & Address Main Member: _____ Work Tel. No.: _____.
_____
_____.
Work Name & Address Spouse: _____ Work Tel. No.: _____.
_____
_____.
Next of Kin: _____ Tel. No.: _____.
(Not Own Address) _____
_____
_____
_____
_____.

Where did you hear about the practice?

Please indicate:

- ☐ Internet search engine (please specify): _____
- ☐ Website (address used): _____
- ☐ Referred by (please name): _____
- ☐ Business card (received from/at): _____
- ☐ Signage on building: _____
- ☐ Advertisement in (please name): _____
- ☐ Other: (please name): _____

Agreement:

I, _____ (Full Names) confirm that the details provided are correct. I further agree to pay my account in full on the day of the consultation and/or treatment, either by Cheque, Cash, EFT or Credit Card. I understand that I will be held liable for any appointments made, that are not kept, unless the appointment has been cancelled at least 2 days in advance.

I understand that Dr Spies is practising as a Natural/Alternative health practitioner using, amongst others Homeopathic and Chinese herbal medicines (under the Allied Health Professions Council of SA). All statements therefore provided reflect a Homeopathic practice number and codes. Dr Spies can not be held responsible for any medicines or services not reimbursed by the relevant medical aid.

I understand that Dr Spies is not practising as a GP (under the Health Professions Council of SA). If Dr Spies deems it more appropriate to consult as a GP in particular situations, he will first motivate why, and only after obtaining written consent, proceed in his capacity as a General Practitioner.

Signed at Cape Town on _____/_____/ 20_____.

_____	_____	_____
Account Holder.	Witness.	For Practice.

New Patient Details & History

Full name/s of patient: _____

Name known by: _____ Male ____ Female: _____

Date of birth: _____ Current Age _____

Own Birth: Natural: (___) / Cesarean Section: (___) Breastfed: (No) / (Yes) ____ (Months) _____

Females: Times Pregnant: _____ Live born children: _____ Miscarriages: _____

Females: Contraception used (In the past): Yes: _____ / No: _____. Type: _____

Contraception used (Currently): Yes: _____ / No: _____. Type: _____

Marital Status: _____ Occupation: _____

Hobbies: _____

Blood Group: _____

Family History & Birth.

Diseases occurring often in Father's family: _____

_____

_____

Father's Health (if still alive) or cause of death and at what age? _____

_____

_____

Diseases occurring often in Mother's family: _____

_____

_____

Mother's Health (if still alive) or cause of death and at what age? _____

_____

_____

Problems with your mother's health or your health during her pregnancy with you: _____

_____

_____

Problems during your mother's birth process with you: _____

_____

_____

Number of Siblings (Brothers & Sisters): _____

Status of health of siblings: Current Age:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Previous Surgery:

Procedure: Year:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____

_____

_____

Important events that lead to deterioration in health: _____

_____

_____

_____

_____

_____

_____

Physical Activity:

Type: Times a Week: Duration:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Chronic conditions already diagnosed & any Prescription medication currently taken for the condition/s:

Year Diagnosed: Condition: Prescription Medicine/s taken & Dosage:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Sources of Water:

Main Source: Tap _____ / Bottle _____ / Filter _____ Filter brand name _____

Alternative Source: Tap _____ / Bottle _____ / Filter _____ Brand name _____

Meals:

I eat breakfast ____ times a week. My typical breakfast is: _____

_____

I eat lunch ____ times a week. My typical lunch is: _____

_____

I eat supper ____ times a week. My typical supper is: _____

_____

Natural Medicines or Herbs or Supplements taken:

Name:	Brand:	Quantity per Day:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Bowel Movement:

Current frequency of bowel movement: _____ per day / _____ per week.

Stools: Normal: _____ Hard: _____ Loose: _____ Colour: _____ Float/Sink: _____

Habits:

Smoking: In the Past (Yes/No) _____ Quantity _____ Currently (Yes/No) _____ Quantity _____

Coffee/caffeinated beverages like energy/diet drinks, colas, or black/green teas: Cups per day: _____

Alcohol: Daily _____ Weekly _____ Occasional _____ Quantity _____ Previous addiction _____

Other Addictive substances; Please specify _____

Current Complaints in order of priority:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

DETOXIFICATION QUESTIONNAIRE

Patient Name: _____ **Date:** _____

Rate each of the following symptoms based on your typical health profile for the specified duration:

✓ Past month

Point Scale: **0**—*Never or almost never* have the symptom **1**—*Occasionally* have it, effect is *not severe* **2**—*Occasionally* have it, effect is *severe*
3—*Frequently* have it, effect is *not severe* **4**—*Frequently* have it, effect is *severe*

I. Medical Symptoms Questionnaire (MSQ)

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia **TOTAL** _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision **TOTAL** _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss **TOTAL** _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation **TOTAL** _____

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores **TOTAL** _____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating **TOTAL** _____

HEART
_____ Chest pain
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat **TOTAL** _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing **TOTAL** _____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain **TOTAL** _____

JOINTS/ MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Feeling of weakness or tiredness
_____ Pain or aches in muscles **TOTAL** _____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating **TOTAL** _____

ENERGY/ ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness **TOTAL** _____

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Poor concentration
_____ Poor physical coordination **TOTAL** _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression **TOTAL** _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge **TOTAL** _____

GRAND TOTAL **TOTAL** _____

Identi-T Stress Assessment

Stress is a normal part of life. Every day, we're faced with stimuli, called stressors, which can elicit the body's "fight or flight" response, setting off a cascade of physiological reactions and resulting in emotions ranging from mild to intense. But while occasional stress is natural and even healthy, chronic or acute stress can be harmful.

Please take a few moments to discover your body's response to situations you perceive as stressful. By honestly assessing how you feel, we can create a natural stress relief program for your individual needs.

Directions:
Please read each statement and circle the number 0, 1, 2, or 3 that best describes your feelings or reactions throughout the course of the day. Determine the subtotal score for each section, then determine the total scores for sections A-C and C-E. Some questions may appear redundant between sections. There's a reason for each question. Don't spend much time on any one question.

0 = Never true 1 = Seldom true 2 = Sometimes true 3 = Often true

When under stress for two weeks or longer, I…

Section A:

1. Get wound up when I get tired and have trouble calming down	0	1	2	3
2. Feel driven, appear energetic but feel "burned out" and exhausted	0	1	2	3
3. Feel restless, agitated, anxious, and uneasy	0	1	2	3
4. Feel easily overwhelmed by emotion	0	1	2	3
5. Feel emotional - cry easily or laugh inappropriately	0	1	2	3
6. Experience heart palpitations or a pounding in my chest	0	1	2	3
7. Am short of breath	0	1	2	3
8. Am constipated	0	1	2	3
9. Feel warm, over-heated, and dry all over	0	1	2	3
10. Get mouth sores or sore tongue	0	1	2	3
11. Get hot flashes	0	1	2	3
12. Sleep less than seven hours a night	0	1	2	3
13. Have trouble falling asleep and staying asleep	0	1	2	3
14. Worry about high blood pressure, cholesterol, and triglycerides	0	1	2	3
15. Forget to eat and feel little hunger	0	1	2	3

Combined Score of all Columns in Section A: _____

Section B:

1. Find myself worrying about things big and small	0	1	2	3
2. Feel like I can't stop worrying, even though I want to	0	1	2	3
3. Feel impulsive, pent up, and ready to explode	0	1	2	3
4. Get muscle spasms	0	1	2	3
5. Feel aggressive, unyielding, or inflexible when pressed for time	0	1	2	3
6. See, hear, and smell things that others do not	0	1	2	3
7. Stay awake replaying the events of the day or planning for tomorrow	0	1	2	3
8. Have upsetting thoughts or images enter my mind again and again	0	1	2	3
9. Have a hard time stopping myself from doing things again and again, like checking on things or rearranging objects over and over	0	1	2	3
10. Worry a lot about terrible things that could happen if I'm not careful	0	1	2	3
Combined Score of all Columns in Section B:				

Section C:

1. Have muscle and joint pains	0	1	2	3
2. Have muscle weakness	0	1	2	3
3. Crave salt or salty things	0	1	2	3
4. Have multiple points on my body that when touched are tender or painful	0	1	2	3
5. Have dark circles under my eyes	0	1	2	3
6. Feel a sudden sense of anxiety when I get hungry	0	1	2	3
7. Use medications to manage pain	0	1	2	3
8. Get dizzy when rising or standing up from a kneeling or sitting position	0	1	2	3
9. Have diarrhoea or bouts of nausea with or without vomiting for no apparent reason	0	1	2	3
10. Have headaches	0	1	2	3
Combined Score of all Columns in Section C:				

Section D:

1. Have trouble organizing my thoughts	0	1	2	3
2. Get easily distracted and lose focus	0	1	2	3
3. Have difficulty making decisions and mistrust my judgment	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Lack the motivation and energy to stay on task and pay attention	0	1	2	3
6. Am forgetful	0	1	2	3
7. Feel unsettled, restless, and anxious	0	1	2	3
8. Wake up tired and unrefreshed	0	1	2	3
9. Experience heartburn and indigestion	0	1	2	3
10. Catch colds or infections easily	0	1	2	3

Combined Score of all Columns in Section D: ____

Section E:

1. Feel tired for no apparent reason	0	1	2	3
2. Experience lingering mild fatigue after exertion or physical activity	0	1	2	3
3. Find it difficult to concentrate and complete tasks	0	1	2	3
4. Feel depressed and apathetic	0	1	2	3
5. Feel cold or chilled - hands, feet, or all over - for no apparent reason	0	1	2	3
6. Have little or no interest in sex	0	1	2	3
7. Sweat spontaneously during the day	0	1	2	3
8. Feel puffy and retain fluids	0	1	2	3
9. Sleep more than nine hours a night	0	1	2	3
10. Have poor muscle tone	0	1	2	3
11. Have trouble losing weight	0	1	2	3
12. Wake up tired even though I seem to get plenty of sleep	0	1	2	3
13. Have no energy and feel physically weak	0	1	2	3
14. Am susceptible to colds and the flu	0	1	2	3
15. Feel dragged down by multiple symptoms, such as poor digestion and body aches	0	1	2	3

Combined Score of all Columns in Section E: ____

Add points from sections A, B & C — Total for A, B & C: _____

Add points from sections C, D & E — Total for C, D & E: _____

Lifestyle and Health Status:

1. Circle the level of stress you experience on the scale of 1-10, 10 being the worst:

1 2 3 4 5 6 7 8 9 10

2. What do you consider to be the major causes of your stress (for example - spouse, family, friends, work, finances, wedding, pregnancy, legal, commute): _____

_____

_____