



**The Riley Fletcher Foundation**  
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better by nature



### CONFIDENTIAL HISTORY

This Questionnaire is designed to collect a comprehensive level of specific and background information in order to help address both the 'cause and effect' of your condition.

There are four sections: Medical History, Emotional Background, Home and Work Environment and Disclaimer.

We recommend you read the Questionnaire first to avoid duplicating answers.

Complete online and e-mail to info@rileyfletcher.com or print off and post to the above address.

Miss  Ms  Mr  Mrs  D.O.B. \_\_\_\_\_

FORENAME: \_\_\_\_\_ SURENAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

POSTCODE: \_\_\_\_\_

TELEPHONE: HOME: \_\_\_\_\_ WORK: \_\_\_\_\_  
CONVENIENT TIME: CONVENIENT TIME:

MARITAL STATUS: \_\_\_\_\_ No. OF CHILDREN: \_\_\_\_\_

LIVING ALONE:  WITH PARTNER:  WITH FAMILY:

### MEDICAL HISTORY

Medication now: \_\_\_\_\_

Smoker  Non smoker:  Your Blood Group

Alcohol consumption: \_\_\_\_\_  
*Units per day* Nil  1/2  3/4  4+  Total weekly units

Describe existing complaint/condition: \_\_\_\_\_ From what date: \_\_\_\_\_

How does it affect you: Like sleeping, eating, working, relationships: \_\_\_\_\_

What do you think may have caused your condition: \_\_\_\_\_

What treatment have you received: Drugs? \_\_\_\_\_ Chemotherapy? \_\_\_\_\_ Complementary Medicine? \_\_\_\_\_

Please describe frequency, period of time and results/reactions: \_\_\_\_\_

Dividing your life into 10 year periods, give information on previous illnesses, drugs, medication, antibiotics/steroids, x-rays, inoculations, anaesthetics, surgery:

1-10 \_\_\_\_\_

11-20 \_\_\_\_\_

21-30 \_\_\_\_\_

31-40 \_\_\_\_\_

41-50 \_\_\_\_\_

51-60 \_\_\_\_\_

61-70 \_\_\_\_\_

over 70 \_\_\_\_\_

Personal or family history of allergies, asthma, headaches, bowel problems or other illnesses:

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Describe your diet, ie do you predominantly eat processed, prepared meals, take-aways, red meat? Do you regularly eat fish and fresh vegetables?

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Do you have regular motions (normal is at least once a day)?

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Have you ever been exposed to chemical or toxic poisons?

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Describe your lifetime dental history. Do you have amalgam fillings or ever had root canals?

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Are you taking any nutritional supplements now? Which supplements?

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What exercise do you take and how regularly?

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Any headaches or blows to the head?

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How did you hear about us?

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If you have any more information you feel is important, please write on the blank section below:

## FAMILY AND EMOTIONAL BACKGROUND

1. Briefly describe your relationship with:

Your father: \_\_\_\_\_

Your mother: \_\_\_\_\_

Your brother(s): \_\_\_\_\_

Your sister(s): \_\_\_\_\_

Your grandparents: \_\_\_\_\_

Your children: \_\_\_\_\_

Your grandchildren: \_\_\_\_\_

Your wife/husband/partner: \_\_\_\_\_

Your girlfriend/boyfriend: \_\_\_\_\_

Special friend/flatmate: \_\_\_\_\_

2. Briefly describe your childhood:

\_\_\_\_\_

3. Describe the cause of any stress levels you experience:

\_\_\_\_\_

4. Describe your work/life balance:

\_\_\_\_\_

5. What is your No 1 priority:

Own my own business       Extra Income       Financial Freedom       Retirement Income

Personal Development       More Time       Meeting people       Helping Others

6. Please state below how you may be affected by any of the following common 'stressors'

Harmful beliefs/attitudes ~ Negative emotions ~ Anger ~ Fear ~ Resentment  
Worry ~ Traumatic events ~ Marriage ~ Divorce ~ Death of loved one ~ Death of pet  
Job stress or loss ~ Move in family ~ Financial loss ~ Relocating

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





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## DISCLAIMER FORM

### CLIENT REQUEST AND AUTHORISATION

I understand the Riley Fletcher Foundation, Riley Fletcher Organisation Limited or Better by Nature remedies/products are not intended to diagnose, prescribe or treat any disease, physical or mental. They are also not intended as a substitute for regular medical or psychiatric care. I am not being advised by the Riley Fletcher Foundation or Riley Fletcher Organisation Limited to discontinue any prescribed medication or medical or psychological care.

I am hereby instructed to consult my personal GP for specific symptoms or medical concerns.

.....  
*Client Signature*

.....  
*Date of Signature*

.....  
*Printed Name of Client*

.....  
*Home Town*

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