The Children's Reflexology Programme

MYMOP2 — INITIAL FORM

Please fill in the form in as much detail as possible.

All information is held in strict confidence

Full name

Address

Date of birth (DD/MM/YY)

Today's date (DD/MM/YY)

Postcode

Practitioner seen

Your own name, if you are filling in this form for someone else

Choose one or two symptoms (physical or mental) which bother you the most. Write them in the boxes.
Now consider how bad each symptom is, over the last week, and score it by circling your chosen number.

		1 2 3 4 5 6
Symptom 1		As GOOD as it could be / As BAD as it could be
Symptom 2		As GOOD as it could be / As BAD as it could be

Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

		1 2 3 4 5 6
Activity		As GOOD as it could be / As BAD as it could be

Lastly how would you rate your general feeling of wellbeing during the last week? 1 2 3 4 5 6 (As GOOD as it could be / As BAD as it could be)

How long have you had Symptom 1, either all the time or on and off? Please tick:

0 - 4 weeks ☐ 4 - 12 weeks ☐ 3 months - 1 year ☐ 1 - 5 years ☐ Over 5 years ☐

Are you taking any medication FOR THIS PROBLEM? Yes ☐ No ☐

Please write in name of medication, and how much a day/week

Is cutting down this medication: Please tick:

Not important? ☐ A bit important? ☐

Very important? ☐ Not Applicable? ☐

Is avoiding this medication: Please tick:

Not important? ☐ A bit important? ☐

Very important? ☐ Not Applicable? ☐

Thank you for your time.

MYMOP:
Measure Yourself Medical Outcome Profile

Please return to:

Susan Quayle
Complementary Healthcare