**HEALTH CHECK QUESTIONNAIRE**

**All details on this questionnaire will be held private and confidential**

**PERSONAL DETAILS** Date:

Please state: Mr [ ]  Mrs [ ]  Miss [ ]  Master [ ]  Dr [ ]  Other [ ]

Surname:       First name:       Marital Status:

Date of birth:       Height:      Weight:      Blood Type

Occupation:

No. of dependents:       Age/sex of children:

Contact address:

Post code:       Contact tel no:      Email address:

Medical doctor’s address:

 Post code:      Doctor’s tel no:

Do you give permission for your medical doctor to be contacted? *“x” for yes* [ ]

Is your medical doctor aware of your intention to see a nutritional therapist? [ ]

Have you seen a nutritional therapist or any other health professional before, regarding your current symptoms? [ ]

How did you hear about the clinic service?

**CURRENT HEALTH**

**Please bring copies of any test results that you have had done previously.**

 **Mark “x” for yes** **Comments**

Are you currently following a medically prescribed diet? [ ]

Are you currently undergoing medical treatment? [ ]

Are you pregnant, or aiming to become pregnant? [ ]

Do you have a medically identified food allergy or intolerance? [ ]

**To be completed in the clinic:**

BMI: BP Heart rate

Please list your four major health concerns in order of importance:

1.

2.

3.

4.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Are you: |  | Explain the type of exercise | Frequency | Duration and… | Place of regular exercise |
| activemoderately activesedentary | [ ] [ ] [ ]  |                    |                    |                    |                    |
| Do you enjoy YES exercise? NO | [ ] [ ]  | If you do not participate in regular exercise, please indicate factors that prevent you from doing so       |

**HEREDITY PROFILE**

Please detail your family’s health: what illness have they had and if they have died, what was the cause (if you know)

Grandfathers:

Grandmothers:

Father :

Mother:

Brothers:

Sisters:

Sons:

Daughters:

**YOUR HEALTH HISTORY**

Against each time in your life please list in the space provided, all significant health problems that you have encountered. Indicate, where appropriate, the duration, timing and management of the health problem. *Please continue on a separate sheet as necessary*.

|  |  |  |  |
| --- | --- | --- | --- |
| Age | Health Problem | Management (eg medication, diet, operation) | Duration |
| 0-3 |       |       |       |
| 3-7 |       |       |       |
| 7-12 |       |       |       |
| 12-18 |       |       |       |
| 18-21 |       |       |       |
| 21-30 |       |       |       |
| 31-40 |       |       |       |
| 41-50 |       |       |       |
| 51-60 |       |       |       |

**MEDICATIONS and SUPPLEMENTS**. Please use a separate sheet if necessary.

Please list below any prescribed drugs, over the counter medicines or supplements or herbs you have taken/ are taking) eg antibiotics, painkillers, HRT, contraceptive pill, warfarin, statins, St John’s wort, multivitamin.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Medication | Dose | Condition being treated | Frequency | Duration | current | past |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |
|       |       |       |       |       | [ ]  | [ ]  |

|  |
| --- |
| Weight History *(please use the space below to describe your weight trends over your lifetime i.e. from birth until now)*      |
| **Are you happy with your weight? Yes** **[ ]  no** **[ ]  If not, then please explain further**  |

**SYMPTOM CHECK**

This is to help to identify if there are any key symptoms that might need medical referral. This is not a definitive list.

*Please mark “x” if you suffer from any of the following.*

|  |  |  |  |
| --- | --- | --- | --- |
| [ ] any unexplained pain[ ] bleeding from nipple[ ] bleeding from vagina[ ] blood in sputum[ ] blood in stool[ ] blood in urine[ ] blood in vomit[ ] blurred vision or dizziness[ ] breast lumps | [ ] calf swelling[ ] change in nature of moles[ ] chest pain[ ] constipation[ ] depression[ ] diarrhoea[ ] difficulty swallowing[ ] discharge from vagina | [ ] excessive thirst[ ] frequent urination[ ] headaches[ ] inability to gain weight[ ] loss of appetite[ ] numbness[ ] paralysis[ ] persistent cough | [ ] persistent nose bleeds[ ] shortness of breath[ ] slurred speech[ ] unexplained bruising[ ] unexplained heavy periods[ ] unexplained loss of periods[ ] unexplained rash[ ] unexplained weight loss |

**Areas of possible Imbalance** *Please mark “x” if you suffer from any of the following:*

|  |  |  |
| --- | --- | --- |
| *Energy*[ ] best evenings[ ] best mornings[ ] difficulty getting to sleep[ ] difficulty getting up[ ] exhaustion[ ] fatigue[ ] feel tired all the time[ ] fluctuating energy[ ] hyperactivity[ ] lethargic[ ] Relax easily | Sleep[ ] dream a lot[ ] difficulty waking up[ ] disordered sleeping pattern[ ] feel sleepy during the day[ ] feel un-refreshed after sleep[ ] get up after 9am[ ] insomniac[ ] need less than 7 hours sleep[ ] need more than 8 hours sleep[ ] shift worker[ ] wake up during the night | Mood[ ] aggression/anger[ ] anxiety/tension[ ] apathetic[ ] competitive[ ] depression[ ] easily provoked[ ] easily satisfied[ ] frustration[ ] hyperactive[ ] irritability[ ] mood swings |
| Circulation[ ] anaemia[ ] angina / chest pain[ ] blood clots[ ] blue extremities[ ] calf pain[ ] cold hands/ feet[ ] high blood cholesterol[ ] low blood pressure[ ] nose bleeds[ ] Pain in legs on walking[ ] thick/thin blood[ ] Thread veins / varicose veins | Digestion + Assimilation[ ] bloating[ ] bolt food[ ] dry mouth[ ] excess saliva[ ] eat on the move[ ] eat when stressed[ ] flatulence[ ] heartburn[ ] indigestion[ ] pain under right rib-cage[ ] pain under right shoulder-blade | Elimination[ ] anal irritation[ ] blood/black stool[ ] constipation[ ] diarrhoea[ ] food poisoning[ ] gall stones[ ] haemorrhoids[ ] infrequent bowel action[ ] offensive stool[ ] pale, bulky stool[ ] stools that float[ ] thrush |
| **Inflammation**[ ] Acne[ ] arthritis[ ] asthma[ ] boils[ ] bronchitis[ ] cancer[ ] conjunctivitis[ ] Crohn’s Disease[ ] cystitis[ ] dermatitis[ ] diverticulitis | [ ] eczema[ ] food allergy/intolerance[ ] gastritis[ ] gingivitis[ ] hay -fever[ ] hepatitis[ ] herpes[ ] hives[ ] IBS[ ] joint pains[ ] labyrnthitis[ ] mastitis | [ ] nephritis[ ] oesophagitis[ ] otitis media[ ] pancreatitis[ ] pelvic inflammatory disease[ ] prostatitis[ ] psoriasis[ ] rhinitis[ ] sinusitis[ ] SLE[ ] Ulcers[ ] urethritis |
| **Toxic Load /Detoxification**[ ] caffeine keeps you awake[ ] cellulite[ ] chronic allergies[ ] chronic headaches[ ] coated tongue[ ] dark circles under the eyes[ ] dark coloured urine[ ] dehydration[ ] drug use including recreational[ ] exercise by busy main roads[ ] feeling of a hangover[ ] feel worse in damp weather[ ] Fluctuating mood[ ] Fluctuating weight | [ ] Eat non-organic fruit and veg[ ] high electrical exposure[ ] high exposure domestic moulds[ ] high intake of oily fish[ ] hormone problems[ ] inflammatory disorder[ ] itching[ ] little fruit or vegetables[ ] live near pylons[ ] live in a city area[ ] live on a farm[ ] mercury fillings[ ] muscle aches[ ] nail infection / athletes foot[ ] offensive body odour[ ] offensive breath | [ ] offensive stools[ ] offensive urine[ ] pesticide exposure[ ] play golf regularly[ ] eat processed foods[ ] regular alcohol[ ] sensitivity to chemicals[ ] signs of premature ageing[ ] smoke cigarettes[ ] unexplained itching/rashes[ ] use garden chemicals[ ] verruca/warts[ ] unwashed fruit and vegetables[ ] water retention[ ] work in a polluted environment[ ] yellow discolouration, skin/eyes |
| **Allergies**[ ] anaphylaxix[ ] been tested by Dr[ ] rheumatoid arthritis[ ] bed-wetting[ ] bloating[ ] carry an epi-pen[ ] excess mucus | [ ] face-ache[ ] Growing pains[ ] hives[ ] itchy nose[ ] itchy skin[ ] itchy eyes[ ] itchy throat[ ] migraines | [ ] mouth ulcers[ ] rashes[ ] red ears[ ] Sneeze a lot[ ] Swollen lips[ ] Swollen throat[ ] Tired after eating[ ] Worse after eating |

**Hormonal History –** *Please mark “x” against any relevant to you*

age of first period?      years old age of final period?      years old

|  |  |  |  |
| --- | --- | --- | --- |
| **Women** |  | **Women** | **Men** |
| [ ]  Are you currently pregnant? [ ] Planning a pregnancy[ ]  Any problems conceiving?[ ]  Any facilitated conception/s?[ ]  Any complications in pregnancy?[ ]  Any history of miscarriage?[ ]  Any complications in labour?[ ]  Any premature births?[ ]  Normal deliveries?[ ]  Have you experienced a stillbirth?[ ] Did you breast-feed?[ ]  Any problems breast-feeding? | [ ]  Regular well woman checks [ ]  Do you have an IUD fitted? [ ]  Currently use the contraceptive pill?[ ] Currently use HRT (synthetic)?[ ] Currently use natural hormones[ ] Any indication of osteoporosis?[ ] Any history of low thyroid function?[ ] Any history of high thyroid function?[ ] Any history of polycystic ovaries?[ ] Any history of fibroids?[ ] Any history of endometriosis?[ ] Any history of hormone cancer? | [ ] Breast lumps[ ] Irregular periods [ ] Mastitis[ ] Painful intercourse[ ] Painful periods[ ] PMS[ ] Heavy periods[ ] Hot flushes[ ] Scant periods[ ]  Vaginal bleeding[ ] Vaginal discharge[ ] Vaginal dryness | [ ] Altered urine flow [ ] Enlarged prostate [ ] Hormone cancer [ ] Impotence [ ] Infertility [ ]  Minimal shaving [ ] Low sperm count [ ] Low sperm motility[ ] Prostatitis |

**INDIVIDUAL BODY TYPE** *Please mark “x” against any relevant to you*

|  |  |  |
| --- | --- | --- |
| [ ]  allergies[ ] anaemia[ ] blood clotting disorders[ ] cancer[ ] chronic fatigue[ ] early onset diabetes[ ] heart disease[ ] inflammatory conditions[ ] intolerant to dietary changes[ ] lupus[ ] multiple sclerosis[ ] reactive immune system[ ]  sensitive digestive tract[ ] ulcers[ ] vulnerable immune system | [ ] addictive/obsessive nature[ ] all boy family[ ] allergies[ ] cry easily[ ] depression[ ] excess salivation[ ] family history of depression[ ] fast metabolism[ ] headaches/migraines[ ] little body hair[ ] light sleeper[ ] long fingers and toes[ ] referred itches[ ] sneeze in bright sunlight[ ] tolerates pain poorly | [ ] abdominal pain/constipation[ ] all girl family[ ] crowded upper front teeth[ ] definite breath/body odour[ ] depression[ ] difficulty remembering dreams[ ] early greying hair[ ] family history of depression[ ] growing pains[ ] infertility/miscarriage[ ] irregular periods[ ] morning nausea[ ] pale skin[ ] stretch marks[ ] white marks on finger nails |
| [ ]  broad chest[ ]  curly hair[ ]  dry warm skin[ ]  energetic[ ]  good sleeper[ ]  gregarious nature[ ]  heavy jaw[ ]  large teeth[ ]  little dental decay[ ]  low hair-line[ ]  physically stocky[ ]  powerful muscle tone[ ]  short neck[ ] thick or short fingers/toes | [ ] creative[ ] defined moons on fingernails[ ] domed forehead[ ] flat-feet[ ] intuitive[ ] knock-knees[ ] large head[ ] large teeth[ ] lax joints[ ] long limbs[ ] stimulant dependency[ ] strong sex drive[ ] tall[ ] tolerates pain well | [ ] dreams a lot[ ] easily aroused[ ] easily fatigued[ ] expressive eyes[ ] fine/silky hair[ ] fine/shapely hands[ ] little body hair[ ] heightened sexuality[ ] long chest/long neck[ ] often dissatisfied[ ] poor concentration[ ] small, narrowly spaced teeth[ ] thin body[ ] wake early and refreshed |

|  |  |
| --- | --- |
| [ ]  addicted to stimulants[ ]  changed jobs[ ]  competitive[ ]  dazzled by lights[ ]  dizzy from sitting to standing[ ]  excessive exercise[ ]  exposure to chemicals / pollutants[ ]  feel too hot or too cold[ ]  financial loss[ ]  food allergies/intolerance[ ]  inflammatory disorder[ ]  insomnia | [ ]  job promotion[ ]  new parent[ ]  physical illness[ ]  physical injury[ ]  recently bereaved[ ]  recently married[ ]  recently moved house[ ]  recently separated[ ]  redundancy/retirement[ ]  regular drug use[ ]  shift worker[ ]  unhappy at home / work |

**STRESSORS** *Please mark “x” against any relevant to you* **GLUCOSE BALANCE**

|  |  |
| --- | --- |
| [ ]  addicted to any foods / cravings[ ]  addicted to any stimulants[ ]  anxiety/tension[ ]  blurred vision[ ]  clammy skin[ ]  depression[ ]  diabetes[ ]  difficulty getting up[ ]  dizziness[ ]  excessive thirst[ ]  excessive urination[ ]  faint/nauseous without regular food[ ]  fluctuating energy | [ ]  high carbohydrate diet[ ]  hyperactivity[ ]  irritability[ ]  low protein diet[ ]  mainly refined foods[ ]  mood swings[ ]  need for frequent meals[ ]  palpitations[ ]  panic attacks[ ]  poor concentration[ ]  poor co-ordination[ ]  sudden weight loss/ gain[ ]  tired after lunch |