**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 |
| active  moderately active  sedentary |  |  |  |  |  |
| 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 |
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| --- |
| 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 |