



**Health Questionnaire
Private and Confidential**

Please consider all questions carefully and answer as accurately as possible

First Name: _____ Surname: _____

Address: _____

_____ Postcode: _____

Tel. No: (Home) _____ Tel. No: (Work) _____

Tel. No: (Mobile) _____ E-mail: _____

Date of Birth: _____ Age: _____ Occupation: _____

Height: (cms) _____ Weight: (kgs) _____ Blood Type: _____

Main reason(s) for visit: _____



Health Concerns:

Date first noticed:

1) _____

2) _____

3) _____

4) _____

5) _____

Current Lifestyle (*please mention exercise, stress, work, commitments, free time etc.*)



Family Health

Do you have any children? If so please state age and sex: _____

Are there any particular illnesses or conditions in your family (e.g., asthma, eczema, heart disease, hay fever etc.)? If so please state which:

Mother: _____

Father: _____

Brothers/Sisters: _____

Children: _____

Please tick the boxes that apply to you, even if they appear more than once

- | | | | |
|--|--------------------------|---|--------------------------|
| Personal or family history of heart disease | <input type="checkbox"/> | Drink more than 14 units of alcohol/wk | <input type="checkbox"/> |
| Have a diagonal earlobe crease | <input type="checkbox"/> | Drink spirits rather than wine | <input type="checkbox"/> |
| High blood pressure | <input type="checkbox"/> | Smoke more than 5 cigarettes daily | <input type="checkbox"/> |
| High cholesterol and/or high blood fat levels | <input type="checkbox"/> | Use vegetable oils in cooking | <input type="checkbox"/> |
| Resting pulse above 80 beats per minute | <input type="checkbox"/> | Eat fried foods more than once/wk | <input type="checkbox"/> |
| Do not exercise regularly (3-4 times per week) | <input type="checkbox"/> | Eat red meat more than 3 times/wk | <input type="checkbox"/> |
| Become easily out of breath | <input type="checkbox"/> | Do not eat any nuts or seeds | <input type="checkbox"/> |
| Suffer from chest pains upon exertion | <input type="checkbox"/> | Do not eat oily fish (salmon, mackerel) | <input type="checkbox"/> |
| Personal or family history of cancer | <input type="checkbox"/> | Have an auto-immune disease | <input type="checkbox"/> |
| Catch more than 2 colds a year | <input type="checkbox"/> | Have an inflammatory disease | <input type="checkbox"/> |
| Prone to infections-eyes, nose, throat, lungs | <input type="checkbox"/> | Lymph glands swollen or sore | <input type="checkbox"/> |
| Prone to cold sores | <input type="checkbox"/> | Prone to thrush or cystitis | <input type="checkbox"/> |
| Prone to swelling or bleeding gums | <input type="checkbox"/> | Have recently taken antibiotics | <input type="checkbox"/> |
| Environmental or chemical sensitivities | <input type="checkbox"/> | Have a history of taking antibiotics | <input type="checkbox"/> |
| Food allergy or intolerance problems | <input type="checkbox"/> | Highly stressed or sensitive to stress | <input type="checkbox"/> |



Please state any known food allergies or intolerances _____

Which foods or drinks would you find the most difficult to give up? _____

- | | | | | | |
|-------------------------|--------------------------|------------------------------|--------------------------|----------------------------|--------------------------|
| Migraines | <input type="checkbox"/> | Tinnitus | <input type="checkbox"/> | Binge or compulsive eating | <input type="checkbox"/> |
| Facial puffiness | <input type="checkbox"/> | Excessive mucous | <input type="checkbox"/> | Food cravings | <input type="checkbox"/> |
| Itchy or watery eyes | <input type="checkbox"/> | General joint pain/stiffness | <input type="checkbox"/> | Hyperactivity | <input type="checkbox"/> |
| Dark circles under eyes | <input type="checkbox"/> | Muscle aches and pains | <input type="checkbox"/> | Itchy skin | <input type="checkbox"/> |
| Sinusitis | <input type="checkbox"/> | Fluctuating fatigue | <input type="checkbox"/> | Psoriasis | <input type="checkbox"/> |
| Excessive sneezing | <input type="checkbox"/> | Fluid retention | <input type="checkbox"/> | Eczema | <input type="checkbox"/> |
| Constant sore throat | <input type="checkbox"/> | Difficulty losing weight | <input type="checkbox"/> | Asthma | <input type="checkbox"/> |
| Earache | <input type="checkbox"/> | Difficulty gaining weight | <input type="checkbox"/> | Hay Fever | <input type="checkbox"/> |
| Glue Ear | <input type="checkbox"/> | Rapid weight fluctuations | <input type="checkbox"/> | Urticaria (Hives) | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|---|--------------------------|
| Fatigue & lethargy not relieved by sleep | <input type="checkbox"/> | Apathy & depression-lack of interest | <input type="checkbox"/> |
| Hard to get up in the morning | <input type="checkbox"/> | Energy slump during the day-esp pm | <input type="checkbox"/> |
| Food allergies or intolerances | <input type="checkbox"/> | Feel better, or 'more alive' in the evening | <input type="checkbox"/> |

- | | | | |
|---|--------------------------|--|--------------------------|
| Poor concentration | <input type="checkbox"/> | Feel light headed/dizzy on standing | <input type="checkbox"/> |
| Irritable, aggressive, less tolerant | <input type="checkbox"/> | Difficulty building muscle or gaining weight | <input type="checkbox"/> |
| Highly stressed or less able to handle stress | <input type="checkbox"/> | Often sweat excessively | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|---|--------------------------|
| Lethargy, fatigue or poor stamina | <input type="checkbox"/> | Outer third of eyebrows thin or lost | <input type="checkbox"/> |
| Weight gain or difficulty losing weight | <input type="checkbox"/> | Depression, difficulty coping | <input type="checkbox"/> |
| Hands/feet sensitive to the cold | <input type="checkbox"/> | Decreased sweating | <input type="checkbox"/> |
| Poor digestion, constipation, wind or bloating | <input type="checkbox"/> | Diminished libido, less interest in sex | <input type="checkbox"/> |
| Dry skin and/or coarse hair | <input type="checkbox"/> | Infertility or multiple miscarriages | <input type="checkbox"/> |
| Excessive hair loss | <input type="checkbox"/> | PMS or menstrual irregularities | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|---|--------------------------|
| Craving for sweets | <input type="checkbox"/> | Headaches | <input type="checkbox"/> |
| Craving for stimulants (tea, coffee, cigarettes) | <input type="checkbox"/> | Often feel agitated, easily upset | <input type="checkbox"/> |
| Fatigue or weakness if a meal is missed | <input type="checkbox"/> | Occ. Shakiness, jitteriness or tremors | <input type="checkbox"/> |
| Irritability or mood swings if a meal is missed | <input type="checkbox"/> | Heart palpitations | <input type="checkbox"/> |
| Feelings of confusion or disorientation | <input type="checkbox"/> | Excessive or frequent urination | <input type="checkbox"/> |
| Awake from sleep feeling tired or restless | <input type="checkbox"/> | Excessive thirst or appetite | <input type="checkbox"/> |
| Poor memory and/or concentration | <input type="checkbox"/> | Breath smells sweet | <input type="checkbox"/> |
| Thoughts less focused, more fuzzy | <input type="checkbox"/> | Unintended weight loss or excessive weight gain | <input type="checkbox"/> |



Female only questions

- | | | | |
|--|--------------------------|--|--------------------------|
| Are you pregnant? If so, how many weeks | <input type="checkbox"/> | Do you use the contraceptive pill/IUD? | <input type="checkbox"/> |
| Are you trying to become pregnant? | <input type="checkbox"/> | PMS-anxiety, irritability, mood swings | <input type="checkbox"/> |
| Have you experienced fertility problems? | <input type="checkbox"/> | PMS-sweet cravings, fatigue, headache | <input type="checkbox"/> |
| Do you have a history of miscarriages? | <input type="checkbox"/> | PMS-weight gain, breast tenderness, bloating | <input type="checkbox"/> |
| Heavy periods | <input type="checkbox"/> | PMS-depression, crying, forgetfulness | <input type="checkbox"/> |
| Irregular periods | <input type="checkbox"/> | Menopausal/Peri-/Post-menopausal | <input type="checkbox"/> |
| Period pains (cramps) | <input type="checkbox"/> | Are you taking HRT? If so, for how long? | <input type="checkbox"/> |

- | | | | |
|---------------------------------------|--------------------------|-------------------------------------|--------------------------|
| Usually eat non-organic foods | <input type="checkbox"/> | Usually cycle to work | <input type="checkbox"/> |
| Do not wash fruit & veg before eating | <input type="checkbox"/> | Job involves working with chemicals | <input type="checkbox"/> |
| Eat tinned foods more than 3 times/wk | <input type="checkbox"/> | More than 3 mercury dental fillings | <input type="checkbox"/> |
| Live or work in a smoky environment | <input type="checkbox"/> | Mercury fillings recently removed | <input type="checkbox"/> |
| Live in a city or near a busy road | <input type="checkbox"/> | Often use recreational drugs | <input type="checkbox"/> |
| Live or work near an industrial plant | <input type="checkbox"/> | Normally drink tap water | <input type="checkbox"/> |

- | | | | |
|---|--------------------------|--------------------------------------|--------------------------|
| Do not chew food properly | <input type="checkbox"/> | Excessive flatulence | <input type="checkbox"/> |
| Prolonged heavy or full feeling after meals | <input type="checkbox"/> | Constipation or diarrhoea | <input type="checkbox"/> |
| Abdominal bloating and discomfort | <input type="checkbox"/> | Weak, peeling, split or ridged nails | <input type="checkbox"/> |

- | | | | |
|--------------------------------|--------------------------|-------------------------|--------------------------|
| History of ulcers or gastritis | <input type="checkbox"/> | Stomach pains | <input type="checkbox"/> |
| Black or tarry stool | <input type="checkbox"/> | Sour taste in the mouth | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|--------------------------------------|--------------------------|
| IBS – alternating constipation & diarrhoea | <input type="checkbox"/> | Roughage & fibre causes constipation | <input type="checkbox"/> |
| Indigestion 1-3 hours after eating | <input type="checkbox"/> | Itching around the rectum | <input type="checkbox"/> |

- | | | | |
|--|--------------------------|--------------------------------------|--------------------------|
| Intolerance to alcohol | <input type="checkbox"/> | Fatty foods cause indigestion/nausea | <input type="checkbox"/> |
| Yellowish cast to the skin or eyes | <input type="checkbox"/> | Bitter taste in the mouth | <input type="checkbox"/> |
| family history of liver/gall bladder disease | <input type="checkbox"/> | Light or clay coloured stool | <input type="checkbox"/> |

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| History of taking antibiotics or NSAIDs | <input type="checkbox"/> | Skin rashes/dermatitis | <input type="checkbox"/> |
| Multiple food allergies or intolerance | <input type="checkbox"/> | Unexplained muscle aches | <input type="checkbox"/> |



Dietary Analysis (please include a weekend in the following 4 days)

Do you have any dietary restrictions (e.g. vegetarian, vegan)? _____

Day 1

Breakfast	Lunch	Dinner
Snacks/Drinks		

Day 2

Breakfast	Lunch	Dinner
Snacks/Drinks		

Day 3

Breakfast	Lunch	Dinner
Snacks/Drinks		

Day 4

Breakfast	Lunch	Dinner
Snacks/Drinks		

