

PRESCRIPTION MEDICATIONS:

Please list any prescription medications that you are currently taking

<u>Medication Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>How long taken?</u> (mths/yrs)	<u>Reason for taking</u>
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ANTIBIOTICS

Childhood: minimal/moderate/considerable

Adulthood: minimal/moderate/considerable

Main reasons for taking antibiotics? eg ear/throat/chest/urinary infections

Are you currently taking antibiotics? Yes/No

CONTRACEPTIVE PILL

Have you ever taken the contraceptive pill for contraception and/or hormonal problems? Yes/No

If so, please indicate ages when taken, eg 18-25:

Did you experience any adverse side effects? Yes/No
If yes, please describe:

Are you currently taking a contraceptive pill? Yes/No

HORMONE REPLACEMENT THERAPY (HRT)

Have you ever taken HRT? Yes/No

If yes, for how many years?

Are you currently taking HRT? Yes/No

ANTI-DEPRESSANTS

Have you ever taken anti-depressants? Yes/No

If yes, for how long? (mths/yrs)

Type/name of medication?

Did you find the medication effective? Yes/No/unsure

OVER THE COUNTER MEDICATIONS (NON-PRESCRIPTION)

Please list any other medications that you take regularly, eg painkillers, antacids, anti-fungals, laxatives

Medication typeReason takenHow often?**NUTRITIONAL SUPPLEMENTS**

Please list any nutritional supplements you are currently taking or have taken in the last 3 years, eg multi-vitamin/mineral, fish oil, probiotics, digestive enzymes, amino acids

SupplementBrand NameDosage/FrequencyCurrent or past**Practitioner Notes:**

FAMILY HEALTH HISTORY

Please list any diseases or health conditions associated with members of your family eg mother, father, brother, sister, son, daughter, paternal grandfather, paternal grandmother, maternal grandfather, maternal grandmother, aunt, uncle, niece, nephew.

Examples may include: Alzheimer's, anorexia, asthma, autism, attention deficit disorder, bulimia, cancer, chronic fatigue, coeliac disease, Crohn's, depression, diabetes, eczema, endometriosis, epilepsy, fibroids, food intolerance, hay fever, heart disease, high blood pressure, high cholesterol, infertility, irritable bowel syndrome, migraine, miscarriage, multiple sclerosis, obesity, osteoarthritis, osteoporosis, overactive thyroid, Parkinson's, polycystic ovaries, rheumatoid arthritis, schizophrenia, ulcerative colitis, underactive thyroid.

<u>Relation</u>	<u>Disease or health condition(s)</u>
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If your parents or grandparents are no longer alive, please give their age and cause of death:

SYMPTOMS: Please indicate if you have experienced any of the following symptoms and whether you consulted your GP:

<u>Symptom</u>	<u>Now</u>	<u>Past</u>	<u>Seen GP</u>
Bleeding from nipple			
Bleeding from vagina			
Blood in sputum			
Blood in urine			
Blood in vomit			
Blurred vision			
Chest pain			
Constipation			
Depression			
Diarrhoea			
Difficulty swallowing			
Dizziness			
Excessive thirst			
Frequent urination			
Headaches			
Heavy periods			
Loss of appetite			
Loss of periods			
Moles			
Numbness			
Paralysis			
Persistent cough			
Persistent nose bleeds			
Shortness of breath			
Swollen glands			
Vaginal discharge			
Unexplained weight loss/gain			

TOXIC LOAD

How many units of alcohol do you consume in the average week? 1 pt beer = 2 units, 175ml wine = 1.5 units

less than 7 7-14 14-21 more than 21

How many caffeinated drinks do you consume each day? Please include coffee, tea, cola and energy drinks

None 1 2 3 4 5 or more

Please choose one of the following statements:

I have never smoked OR I used to smoke

OR I currently smoke ___ cigarettes per day

Please indicate whether you are currently, or have in the past, been exposed to any of the following:

High Moderate Light

- Aircraft flights
- Copper or lead water pipes
- Moulds
- Home DIY
- Gardening
- Live in a city area
- Live on a farm
- Mercury fillings
- Pesticides
- Processed foods
- Play golf
- Recreational drugs
- Work with paints/chemicals

WEIGHT HISTORY

Please use the space below to describe your weight trends over your lifetime (ie from birth until now):

Are you currently happy with your weight? Yes/No

If no, please explain further:

DIGESTION AND ELIMINATION

Do you currently experience, or have experienced in the past, any of the following:

Now Past

Abdominal pain
Acid reflux
Anal irritation
Black stool
Bloating
Bolt food
Bulky stool
Constipation
Diarrhoea
Difficulty chewing
Dry mouth
Eat on the move
Eat when stressed
Excess saliva
Food poisoning
Flatulence
Gall stones
Haemorrhoids
Heartburn
Hiatus hernia
Incomplete motion
Indigestion
Irritable bowel syndrome (IBS)
Mucus in stool
Morning nausea
Nausea
Offensive stool
Pain under right rib cage
Pale stool
Parasites
Stools that sink
Stools that float
Thrush
Worms

INFLAMMATION

Do you currently experience, or have experienced in the past, any of the following:

Now Past

Acne
Arthritis
Asthma
Boils
Bronchitis
Cancer
Conjunctivitis
Crohn's disease
Cystitis
Dermatitis
Diverticulitis
Eczema
Food allergy
Food intolerance
Gastritis
Gingivitis
Hay fever
Heart disease
Herpes
Hepatitis
Hives
Irritable Bowel Syndrome (IBS)
Joint pains
Mastitis
Nephritis
Oesophagitis
Otitis media
Pancreatitis
Pelvic inflammation
Prostatitis
Psoriasis
Rhinitis
Sinusitis
SLE (lupus)
Ulcers
Urethritis

ALLERGY OR INTOLERANCE

List any foods, chemicals, or other substances (eg pollen, cat hair) that you react to:

Were these diagnosed by a doctor?
Yes/No

Have you ever been hospitalised with an allergic reaction? Yes/No

Do you carry an epi-pen? Yes/No

Do you experience any of the following symptoms, which are not linked to known allergies or intolerances?

Anaphylaxis
Abdominal discomfort after eating
Bloat after eating
Diarrhoea
Excess Mucus
Face ache
Hives
Itchy eyes
Itchy nose
Itchy skin
Itchy throat
Migraines
Mouth ulcers
Rashes
Red ears
Sneeze a lot
Swollen lips
Swollen throat
Tired after eating
Feel worse after eating

Practitioner Notes:

ENERGY, SLEEP AND MOOD

Please indicate which of the following apply to you

- Addictive
- Apathetic
- Asleep after midnight
- Asleep before midnight
- Aggressive
- Angry
- Anxious
- Best in evenings
- Best in mornings
- Competitive
- Creative
- Cry Easily
- Depressed
- Difficulty getting to sleep
- Difficulty getting up
- Difficulty waking up
- Dream a lot
- Dull
- Easily aroused
- Easily fatigued
- Easily provoked
- Easily satisfied
- Exhausted
- Fatigued
- Feel sleepy during the day
- Feel tired all the time
- Fluctuating energy
- Foggy brain
- Frustrated
- Get up after 9am
- Hard to relax
- Heavy sleeper
- Hyperactive
- Hypercritical
- Insomniac
- Intuitive
- Irritable
- Light sleeper
- Mood swings
- Obsessive
- Often dissatisfied
- Passive
- Poor concentration
- Poor memory
- Remember dreams easily
- Relax easily
- Sad
- Self centred
- Shift worker
- Sleep less than 7 hours
- Sleep more than 7 hours
- Snore
- Tense
- Wake during the night
- Wake refreshed
- Wake unrefreshed

Any other comments about your energy, sleep or mood?

SOURCES OF STRESS

Please indicate if any of the following apply to you now or in the recent past (< three years)

Now Past

- Bereavement
- Changed jobs
- Excessive exercise
- Financial loss
- Job promotion
- Legal problems
- Marriage
- Moving home
- New parent
- Overcommitted
- Pain
- Physical illness
- Physical injury
- Redundancy
- Retirement
- Separation
- Divorce
- Unclear goals
- Unhappy at home
- Unhappy at work

Other stressors in your life:

Do you experience any of the following?

- Dazzled by lights
- Dizzy sitting to standing
- Excessive sweating
- Feel too hot or too cold
- Panic attacks
- Palpitations

How is your response to stress?

Good OK Poor

What measures do you take to manage stress?

CIRCULATION

Do you currently experience, or have experienced in the past, any of the following:

Now Past

- Anaemia
- Angina
- Blood clots
- Blue extremities
- Calf pain
- Chest pain
- Cold hands and feet
- Groin pain
- Fatty arteries
- Hardened arteries
- High blood pressure
- High cholesterol
- High triglycerides
- Low blood pressure
- Lung disease
- Nose bleeds
- Obesity
- Pain in legs on walking
- Red face
- Stroke
- Thick blood
- Thin blood
- Thread veins
- Varicose veins

EXERCISE

Please choose one of the following to describe your usual lifestyle:

Very active Fairly active
Sedentary

If you take regular exercise, please describe the nature and frequency (eg. walk 2 x 45 mins per week, visit gym 3 x 30 mins per week):

Do you enjoy the exercise that you take? Yes/No

If you do not exercise regularly, what is stopping you from doing so?

Practitioner Notes:

HORMONAL HISTORY – WOMEN ONLY. Please indicate if applies.		HORMONAL SYMPTOMS – WOMEN <u>Now</u> <u>Past</u>
Are you currently pregnant? Are you planning a pregnancy? Any problems conceiving? Any facilitated conceptions? Any complications in pregnancy? Any history of miscarriage Any complications in labour? Any premature births? Normal deliveries? Have you experienced a still birth? Did you breast feed? Any problems breastfeeding?	Do you have regular well women checks? Do you have an IUD fitted? Do you currently use the contraceptive pill? Do you currently use HRT? Do you 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 a hormone-related cancer?	Breast lumps Irregular periods Mastitis Painful intercourse Painful periods Hot flushes Scant periods Vaginal bleeding Vaginal discharge Vaginal dryness

GENERAL SYMPTOMS (associated with regulatory systems)	HORMONAL SYMPTOMS – MEN <u>Now</u> <u>Past</u>
Abdominal weight gain Acne Addicted to food Addicted to stimulants Bleeding gums Crave sweet food Crave salty food Cry easily Dry hair Dry eyes Excessive body hair Excessive salivation Excessive sweating	Fluctuating weight Hair loss Hair prematurely grey High pain threshold High sex drive Low pain threshold Low sex drive Painful or purple tongue Poor appetite Poor eyesight Poor dental health Poor nail health Slow wound healing

PLEASE GIVE ANY OTHER INFORMATION ABOUT YOUR HEALTH WHICH HAS NOT BEEN COVERED IN THE ABOVE SECTIONS:

Practitioner Notes:

DIETARY HABITS Do you:

Add salt to cooking or food?
Avoid additives and preservatives?
Choose mainly low fat foods?
Eat a lot of chocolate/confectionery?
Eat a lot of high fat foods?
Eat a lot of ready meals?
Eat red meat 3+ times weekly?
Mainly cook with olive oil?

Mainly cook with vegetable oils?
Mainly drink tap water?
Mainly use butter?
Mainly use margarine/ or spreads?
Regularly drink fruit juice?
Regularly eat cakes and biscuits?
Regularly eat microwaved food?
Regularly eat takeways/fast food?

Eat out frequently?
Cook for more than one?
Enjoy entertaining?
Enjoy preparing food?
Find shopping easy?
Live alone?
Shop online for food?
Visit the supermarket weekly?

List your favourite foods

List the foods you most dislike

Do you follow a special diet?
eg vegetarian, vegan, wheat free

FOOD DIARY Please give an indication of your typical diet on a weekday, Saturday and Sunday. Record all food, drink and timings, including snacks. Please give an indication of portion size eg 2 slices, 1 bowl, 2 tbsp, 1 mug, 1 cup, 1 tsp. Remember to include teas, coffees, water, soft drinks and alcohol. Example: 8am: bowl of muesli with semi-skimmed milk, banana, 1pm: 1 chicken breast and large salad.

<u>Weekday</u>	<u>Saturday</u>	<u>Sunday</u>

Practitioner notes: