Health Questionnaire

Date

Name

Date of Birth

Place of Birth

Time of Birth

What long term health goals are you working toward?

What are the health challenges that you would like to work with for this session:

1
2
3

Symptoms:

Medical History: *(Please list any operations & diseases which have effected your health and wellbeing.)*

Please tick everything applicable and provide details as appropriate

Abdominal distension/bloating after eating
Allergies
Apendicitis
Anxiety/Panic Attacks
Arthritis/Rheumatism
Asthma
Back Ache
Blood Clots
Breathlessness
Bronchitis
Cancer
Chronic fatigue/Fybromyliga
Common cold/Sore throat/congestion/tonsilitis
Constipation
Deep Vein Thrombosis (DVTs)
Depression
Diarrohoea
Digestive disorders
Dizziness
Ecezma
Emotional outbursts / problems
Emphysema
Epilepsy
Feel the cold generally
Feel hot generally
Food cravings - Sweet, Salt, Bitter, Spicy, Sour
Haemorrhoids
Headaches/Migraine
Heart attack/heart problems
High Blood pressure
Hot Flushes
Influenza/ fevers
Please detail any other dis-ease not included above?

Insomnia/Disturbed Sleep
Joint Pain
Lack of Energy
Low blood pressure
Night Sweats
Numbness in Limbs
Osteoporosis
Palpitations
Poor circulation/Cold hands and feet
Poor hearing
Poor memory
Poor vision
Psoriasis
Repetitive Strain Injury
Ross River Fever
Scoliosis
Sinusitis
Sports injuries
Stiff neck and shoulders
Stress & tension
Tinnitus
Varicose Veins
Whiplash

Womens Issues

Candida/Thrush/Vaginal Discharge
Endometriosis
Fibroids
Heavy Bleeding / Flooding
Irregular cycles
No or light bleeding
Painfull Menses
Premenstrual Syndrome (PMS)
Taking the Pill

Pleae list any medications you are taking.

Questionairre:

1 Number of organs removed?

2 Number of synthetic drugs used currently?

3 Amount of cigarettes, cigars etc you smoke per day?

4 Number of steroid type drugs used in the last year?

5 Number of metal amalgam fillings?

6 Number of street drugs used per month?

7 Number of known allergies

8 Number of unresolved mental factors?

9 I am responsible for my body 0 min 10 max 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

19 Amount of fat in the diet as a percentage of diet include processed foods and divide by 10?

11 Personal stress - rate out of 10, where 10 is maximum.

12 Number of sugar products consumed per day, include soft drinks, ice cream, cake, sugar in tea coffee etc

13 Number of exercise sessions per week of 20 mins or more duration. Do not include work.

14 Number of alcoholic drinks per day on average.

15 Number of cups of caffiene products per day on average, include tea, coffee, caffiene energy drinks

16 Number of extreme toxic exposures in last year. Include xrays, radiation, insecticides, chemicals.

17 Number of major injuries in the past, include surgeries.

18 Number of major infections past and present.

19 Number of glasses of water per day.

20 How many kilograms overweight. 1 kg = 2.2lbs.

21 I have a **pacemaker.** Y/N

21 I am or may be **pregnant.** Y/N

22 I am on blood thinning medication. (Asprin, Heparin Warfarin etc.) Y/N

23 In the last 12 months I have completed a detox. Y/N

24 I am allergic to nuts. If so my safe oils are: Y/N

- ☐ Olive
- ☐ Sesame
- ☐ Almond
- ☐ Jojoba
- ☐ Rice Bran
- ☐ Safflower/Sunflower
- ☐ Coconut
- ☐ Other……..