Health Questionnaire

99 Life in Print
Lived experience becomes a plan

INSTRUCTIONS

1. Save this file to your computer first (do not open from email).
2. Open using Acrobat Reader, fill in, save and email back using the link on the last page.
3. Do NOT fill out using "Preview". If you don't have Acrobat Reader, you can download it here.

Don't worry if you leave some questions blank. We will go over everything in detail during our consultation.

YOUR CONTACT DETAILS

NAME

ADDRESS

EMAIL

PHONE

All information will be kept confidential in accordance with EU GDPR

PERSONAL DETAILS

D.O.B. AGE SEX M F

HEIGHT WEIGHT

IS YOUR WEIGHT INCREASING DECREASING STABLE

BLOOD PRESSURE HIGH LOW NORMAL

OCCUPATION

NUMBER OF DEPENDANTS

GP NAME & ADDRESS

Health Questionnaire

MAIN REASON FOR CONSULTATION

Please write the symptom that affects you the most below
(e.g. fatigue, headaches, weight gain)

Please select below how severe the symptom has been in the last two weeks.

1	2	3	4	5	6	7	8	9	10

mild ⟷ severe

How long has this symptom been an issue?

How are you managing this symptom?

Do you suspect any triggers?

What are you hoping to achieve through nutritional therapy? Why?

MEDICAL HISTORY

Please list below all other diagnosed medical conditions and/or periods of ill health with approximate dates. Included biopsies, surgery, broken bones etc. (e.g. diagnosed Type 2 diabetic 2012, asthmatic since 2006)

CURRENT MEDICATIONS - Please list all medications you are currently taking, how long you've been on them and dosages

CURRENT SUPPLEMENTS - Please list all supplements you are currently taking, how long you've been on them and dosages

FAMILY HISTORY - please list any illnesses that run in your family, including grandparents and siblings.

LIFESTYLE

SLEEP / ENERGY	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Trouble falling asleep			
Waking too early			
Waking frequently			
Waking unrefreshed			
Recalls dreams easily			
Nightmares			
Sleep apnoea			
Loud snoring			
Use phone / tablet in bed			
Shift worker			
Need sugar or caffeine to keep going			

What is your usual bedtime?	
What time do you usually wake?	
What is your ideal number of hours of sleep per night?	
Please list anything you use to help you get to sleep.	

When is your energy the lowest?	☐ on waking	☐ after lunch
	☐ mid afternoon	☐ evening

Please list below any exercise you do and how often		
How do you feel after exercising?	☐ re-energised	☐ depleted

WORK / LIFE BALANCE

What are the main stressors in your life at the moment?		
Do you have enough support?	☐ YES	☐ NO

What do you do to relax? (e.g. read, meditation, watch tv)		
Do you find it easy to switch off?	☐ YES	☐ NO
Do you feel guilty relaxing?	☐ YES	☐ NO

SYMPTOM CHECKER - Please tick all that apply, even if symptom is repeated in a new section

BLOOD SUGAR	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Feeling wired / overwhelmed	○		○
Can't switch off	○		
Extra fat around the middle	○		
Energy slumps during the day	○		
Mood swings / irritability	○		
Sugar cravings		○	○
Salt cravings			
Carb cravings			
Decrease in libido			
Excessive thirst			
Excessive urination			
Irritable or dizzy before eating			
Fungal infections			
Insomnia - can't fall asleep			
Insomnia - early hours waking			
Frequent colds / infections			
Skin tags			
Other symptoms (please list):			

THYROID	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Fatigue (all day)			
Weight gain			
Dry skin			
Cold hands / feet			
Brittle nails			
Brain fog / memory loss			
Hair loss			
Outer eyebrow thinning			
Anxiety			
Low libido			
Depression			
Constipation			
Infertility			
High cholesterol			
Family History	☐ YES	☐ NO	
Other symptoms (please list):			

SYMPTOM CHECKER - Please tick all that apply, even if symptom is repeated in a new section

GENERAL	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Sore tongue			
Tooth decay			
Root canals			
Mouth ulcers			
Difficulty swallowing			
Poor sense of taste			
Dry mouth			
Bleeding gums			
Gum disease			
Bad breath			
Eczema or psoriasis			
Acne			
Dry flaky skin			
Excessive sweating			
Lack of sweating			
Hair falling out			
Hair thinning			
Brittle nails			
White spots on nails			
Flaking nails			
Fungal nail infections			

GENERAL	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Dark circles under eyes			
Puffy eyes			
Poor night vision			
Blurred vision			
Dry eyes			
DETOXIFICATION			
Drinks alcohol			
Caffeine use			
Eats organic food			
Eats processed foods			
Smokes (including vape etc)			
Frequent flyer			
Drinks out of plastic			
Stores / heats food in plastic			
Exposure to damp / mould			
Recreational drug use			
Exposure to chemicals at work (e.g. hairdresser, cleaner, dentist) please explain below:			

SYMPTOM CHECKER - Please tick all that apply, even if symptom is repeated in a new section

MUSCULO-SKELETAL	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Joint pain			
Muscle pain			
Back pain			
Numbness / tingling			
Muscle cramps			
Restless legs			
Osteopaenia / Osteoporosis			
NERVOUS SYSTEM			
Periods of low mood			
Depression			
Anxiety			
Feeling overwhelmed			
Panic attacks			
Vertigo			
Dizziness			
Insomnia - can't fall asleep			
Insomnia - early hours waking			
Frequent headaches			
Numbness / tingling			
Travel sickness			

CARDIOVASCULAR	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Chest pain			
Shortness of breath			
Swelling of legs			
Fainting			
High blood pressure			
Low blood pressure			
Varicose veins			
Cold extremities			
High cholesterol			
Tinnitus			
RESPIRATORY			
Asthma			
Bronchitis			
Wheezing			
Sinusitis			
Chronic cough			
Tonsillitis			
Ear infections			
Other symptoms (please list):			

SYMPTOM CHECKER - Please tick all that apply, even if the symptom is repeated in another section

DIGESTION	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Constipation			
Diarrhoea			
Blood in stool			
Mucus in stool			
Reflux / Heartburn			
Bloating			
Cramping, urgency to go			
Sensation of fullness			
Stomach ulcers			
Haemorrhoids			
Anal itching			
Excessive belching			
Excessive flatulence			
Nausea			
Indigestion			
Change in appetite			
Diverticulitis			
Greasy, floating stools			
Undigested food in stools			
Very foul-smelling stool			

BRISTOL STOOL CHART

Your poo says a lot about you! Please tick below the types of bowel movements that you have most frequently. You may tick all that apply.

- ☐ 1. Separate hard lumps, hard to pass
- ☐ 2. Sausage-shaped but lumpy
- ☐ 3. Sausage-shaped with cracks on the surface
- ☐ 4. Sausage-shaped, smooth and soft
- ☐ 5. Soft blobs with clear-cut edges
- ☐ 6. Mushy stool, fluffy pieces with ragged edges
- ☐ 7. Watery, no solid pieces, all liquid

How many bowel movements do you have per day? ☐

What colour are they normally?

- ☐ BLACK, TARRY
- ☐ MEDIUM TO DARK BROWN
- ☐ LIGHT BROWN OR YELLOWISH
- ☐ VERY PALE
- ☐ GREENISH

Bristol Stool Chart originally created by Kyle Thompson and released under a Creative Commons Attribution license

Health Questionnaire

FEMALE ONLY - Please skip to next section if male

UROGENITAL / OESTROGEN	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Chronic UTIs / Cystitis			
Thrush			
Frequent urination			
Bacterial Vaginosis			
Pain during intercourse			
Pelvic pain			
Breast tenderness			
Water retention			
Mood swings			
Acne			
Anxiety			
Fibroids			
Endometriosis			
Polycystic ovaries			
Menstrual migraines			
Hot flushes			
Memory loss / brain fog			
Vaginal dryness			
Decrease in libido			
Night sweats			
Tearfulness			

REPRODUCTIVE (PRE-MENOPAUSE ONLY)

ARE YOU MENSTRUATING? ☐ Y ☐ N

IS YOUR CYCLE REGULAR? ☐ Y ☐ N

CYCLE LENGTH (e.g. 28 days)

CYCLE DURATION (e.g. 5 days)

FLOW ☐ LIGHT ☐ MEDIUM ☐ HEAVY ☐ FLOODING OR CLOTS

☐ SPOTTING BETWEEN PERIODS

ARE YOU PREGNANT? ☐ Y ☐ N

IF YES, LIST DUE DATE

ARE YOU BREASTFEEDING? ☐ Y ☐ N

WHAT CONTRACEPTION DO YOU CURRENTLY USE?

HOW LONG HAVE YOU BEEN TAKING IT?

NUMBER OF CHILDREN

FERTILITY ISSUES? ☐ Y ☐ N

HAVE YOU HAD ANY MISCARRIAGES? ☐ Y ☐ N

PLEASE EXPLAIN OR ADD ADDITIONAL SYMPTOMS BELOW:

MALE ONLY - Please skip to next section if female

UROGENITAL	NEVER	MODERATE or SOMETIMES	SEVERE or FREQUENT
Chronic UTIs			
Thrush			
Frequent urination			
Pain on ejaculation			
Pain during intercourse			
Decrease in libido			
Erection issues			
Variocele			
Lower mood / grumpiness			
Decrease in work performance			
Decrease in muscle strength			
Decrease in endurance			
Falling asleep after eating			
Fatigue			

ANY OTHER SYMPTOMS, PLEASE EXPLAIN BELOW:

FOOD DIARY

Please list the meals you normally have over the course of a week, including some weekend examples if they differ (e.g. home-cooked meals instead of work sandwiches). Please also include the times you normally eat.

ARE YOU ON A SPECIAL DIET? ☐ Y ☐ N IF YES, PLEASE SPECIFY: (e.g. vegan, gluten free etc..)

TYPICAL BREAKFASTS	**TYPICAL LUNCHES**	**TYPICAL DINNERS**	**REGULAR SNACKS / TREATS**
Breakfast time weekdays:	Lunch time weekdays:	Dinner time weekdays:	Snack times weekdays:
Breakfast time weekends:	Lunch time weekends:	Dinner time weekends:	Snack times weekends:

Glasses of water per day:	
Cups of caffeinated drinks per day (tea, coffee, soda):	
Units of alcohol per week (beer, wine, spirits):	
Other drinks (please specify)	

FAVOURITE FOODS Please list any foods you would find very difficult to give up and why

FOOD AVERSIONS Please list any foods you cannot tolerate and explain why

The Patient understands and agrees to the following:

- I am responsible for contacting my GP about any health concerns.
- I give permission for the therapist to contact my GP regarding any agreed aspects of my case.
- If I am receiving treatment from my GP, or any other medical provider, I should tell him/her about any strategy provided by my therapist. This is necessary because of any possible reaction between medication and other programmes I may be involved with.
- It is important that I am open about any medical diagnosis, medication, herbal medicine, or food supplements, I am taking as this may affect my treatment.
- I understand that any advice is personal to me and may not be appropriate for others.
- Recording consultations using any form of electronic media is not allowed without the written permission of both the Client and Consultant.

Data Protection

Consultants may share my sensitive information with third parties to support my ongoing healthcare. If we do not receive this consent from you, we will not be able to coordinate your healthcare with other providers which means the healthcare provided by us may be less effective.

Please confirm your consent at the end of this document.

We may also share your contact information with biochemical testing companies to order tests as part of your healthcare.

Please tick the box at the end of the form to confirm your consent.

Marketing and Information

We may like to contact you occasionally by email with promotional offers, information on upcoming events and activities, and newsletters. Please tick the boxes at the end of this form to confirm your consent.

Case Histories

We may want to share case histories to improve our practice through professional development.

This could be through conferences, lectures, online forums, and publishing in medical journals, trade magazines or online professional sites.

Case histories will be anonymous.

Your name, address and contact details will never be used when sharing case histories.

If you are happy for your data to be used for this purpose, please tick the box at the end of the form.

Continued on next page

Health Questionnaire

We understand the information in this document and agree that our professional relationship will be based on the content of this document. We declare that all the information we share during this professional relationship is confidential and to the best of our knowledge, true and correct. Signing below is confirmation of this.

Data Protection Consent

- I consent to my sensitive information being shared with other healthcare providers as necessary (e.g. testing companies, labs)
- I consent to my sensitive information being shared with my GP
- I consent to receiving email communications from Life in Print about but not limited to articles, free training and special offers. I can withdraw my consent to the above communications at any time by clicking on the unsubscribe link at the bottom of every email.
- I consent to my data being used for the purpose of professional development (e.g. Case Studies). Data will be anonymous, my name and details will not be used.

I can withdraw my consent to the above data usage at any time by emailing the contact details. All data is processed in accordance with Life in Print's privacy policy.

Your signature is required below

DATE

CLIENT SIGNATURE

Please click the box and follow directions to use a digital signature

CLIENT NAME

CLIENT EMAIL

Practitioner's signature and details

PRACTITIONER SIGNATURE

Name and Speciality:

Email:

Contact No: +44 (0)

Please submit form by attaching it to an email addressed to:
help@life-in-print.com