

# Health Check

All details on this questionnaire will be held private and confidential.  
Please answer all questions as accurately as possible to facilitate a  
nutritional programme being designed to best meet your needs.

DATE \_\_\_\_\_ TITLE Mr Mrs Miss Ms Master Dr

SURNAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_

OCCUPATION \_\_\_\_\_ DATE OF BIRTH / / \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

CULTURAL ORIGINS \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

CONTACT DETAILS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
POST CODE \_\_\_\_\_  
LANDLINE \_\_\_\_\_  
MOBILE \_\_\_\_\_  
EMAIL \_\_\_\_\_

GP CONTACT DETAILS:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
POST CODE \_\_\_\_\_  
TELEPHONE \_\_\_\_\_

AGE/SEX OF CHILDREN \_\_\_\_\_  
AGE/SEX OF SIBLINGS \_\_\_\_\_

ARE YOU CURRENTLY SEEING YOUR GP FOR ANY HEALTH PROBLEMS?  
YES / NO  
IS YOUR GP AWARE OF YOU SEEKING NUTRITION SUPPORT?  
YES / NO  
DO YOU GIVE PERMISSION FOR YOUR GP TO BE CONTACTED?  
YES / NO  
HAVE YOU SOUGHT PROFESSIONAL NUTRITIONAL ADVICE IN THE PAST?  
YES / NO  
ARE YOU CURRENTLY SEEING ANY OTHER COMPLEMENTARY HEALTH CARE PRACTITIONER?  
YES / NO  
HAVE YOU SEEN A COMPLEMENTARY HEALTH OR ANY OTHER HEALTH PRACTITIONER (OTHER THAN GP) IN THE PAST?  
YES / NO  
DO YOU GIVE PERMISSION FOR YOUR CONSULTATION TO BE OBSERVED BY A STUDENT OR OTHER PROFESSIONAL?  
YES / NO (delete as appropriate)

ANY ADULT DEPENDENTS? (If yes, please briefly elaborate)

Briefly describe how you heard about this service?

What is/are your main reasons for seeking nutritional support?

Briefly describe what you hope to gain from nutritional support for the short and long term?

Briefly describe what you perceive as your strengths and limitations with regard to your current diet and lifestyle

FOR PRACTITIONER USE



**FAMILY HISTORY**

Indicate as best you can which family members were/are prone to any of the following disorders:

grandparents GM or GF, parents M or F, sibling B or S, cousins (if known) CM or CF, children CHM or CHF don't know DK

(As a double-check on your own health issues put SF for self if any condition applies to you personally)

**MATERNAL**

**PATERNAL**

Addictive/Obsessive	_____	_____
Alzheimer's disease	_____	_____
Artery disease	_____	_____
Asthma	_____	_____
Attention Deficit	_____	_____
Autism	_____	_____
Cancer	_____	_____
Chemical Sensitivities	_____	_____
Chronic fatigue	_____	_____
Coeliac disease	_____	_____
Constipation	_____	_____
Depression	_____	_____
Diabetes	_____	_____
Disordered Eating	_____	_____
Eczema	_____	_____
Endometriosis	_____	_____
Epilepsy	_____	_____
Fibroids	_____	_____
Food Intolerance	_____	_____
Hayfever	_____	_____
Headaches	_____	_____
High blood pressure	_____	_____
High cholesterol	_____	_____
Infections	_____	_____
Infertility	_____	_____
Insomnia	_____	_____
Irritable Bowel	_____	_____
Learning Difficulties	_____	_____
Migraines	_____	_____
Multiple sclerosis	_____	_____
Miscarriage	_____	_____
Obesity	_____	_____
Osteoarthritis	_____	_____
Osteoporosis	_____	_____
Overactive thyroid	_____	_____
Overweight	_____	_____
Parkinson's disease	_____	_____
Polycystic Ovaries	_____	_____
Poor stress response	_____	_____
Prematurity	_____	_____
Raynaud's disease	_____	_____
Rheumatoid Arthritis	_____	_____
Schizophrenia	_____	_____
Sinusitis	_____	_____
Sjrogen's disease	_____	_____
Underactive thyroid	_____	_____
Underweight	_____	_____
Other	_____	_____

Are your parents alive and well? YES / NO \_\_\_\_\_

Are your grandparents alive and well? YES / NO \_\_\_\_\_

(If you answered NO to the above questions please indicate in the space provided the age when either your parent/s or grandparent/s died and as far as you know the cause of their death)

**PRACTITIONER COMMENTS**

<p>Have you consulted your GP for any of the following symptoms? Please indicate in the space provided whether this is: <b>C = current</b>      <b>RP = recent past</b> <b>P = past</b></p> <p>Bleeding from nipple _____</p> <p>Bleeding from vagina _____</p> <p>Blood in sputum _____</p> <p>Blood in urine _____</p> <p>Blood in vomit _____</p> <p>Blurred vision _____</p> <p>Breast lumps _____</p> <p>Calf swelling _____</p> <p>Chest pain _____</p> <p>Constipation _____</p> <p>Depression _____</p> <p>Diarrhoea _____</p> <p>Difficulty swallowing _____</p> <p>Dizziness _____</p> <p>Excessive thirst _____</p> <p>Frequent urination _____</p> <p>Headaches _____</p> <p>Heavy periods _____</p> <p>Loss of appetite _____</p> <p>Loss of periods _____</p> <p>Moles _____</p> <p>Numbness _____</p> <p>Paralysis _____</p> <p>Persistent cough _____</p> <p>Persistent nose bleeds _____</p> <p>Shortness of breathe _____</p> <p>Slurred speech _____</p> <p>Swollen glands _____</p> <p>Unexplained pain _____</p> <p>Vaginal discharge _____</p> <p>Weight gain _____</p> <p>Weight loss _____</p> <p>Please list other reasons why you have consulted your GP.</p> <p>_____</p> <p>_____</p>	<p><b>Digestion &amp; Elimination</b> <b>C = current</b> <b>RP = recent past</b> <b>P = past</b></p> <p>Abdominal pain _____</p> <p>Anal irritation _____</p> <p>Black stool _____</p> <p>Bloating _____</p> <p>Bolt food _____</p> <p>Bulky stool _____</p> <p>Constipation _____</p> <p>Diarrhoea _____</p> <p>Difficulty chewing _____</p> <p>Dry mouth _____</p> <p>Eat on the move _____</p> <p>Eat when stressed _____</p> <p>Excess saliva _____</p> <p>Food poisoning _____</p> <p>Flatulence _____</p> <p>Gall stones _____</p> <p>Haemorrhoids _____</p> <p>Heartburn _____</p> <p>Hiatus hernia _____</p> <p>Incomplete motion _____</p> <p>Indigestion _____</p> <p>Irritable bowel syndrome _____</p> <p>Mucus in stool _____</p> <p>Morning nausea _____</p> <p>Nausea _____</p> <p>Offensive stool _____</p> <p>Pain under right rib cage _____</p> <p>Pale stool _____</p> <p>Parasites _____</p> <p>Pus in stool _____</p> <p>Reflux _____</p> <p>Stools that sink _____</p> <p>Stools that float _____</p> <p>Thrush _____</p> <p>Worms _____</p>	<p><b>Inflammation</b> <b>C = current</b>      <b>RP = recent past</b>      <b>P = past</b></p> <p>Acne _____ IBS _____</p> <p>Arthritis _____ Infections _____</p> <p>Asthma _____ Joint pains _____</p> <p>Boils _____ Labyrinthitis _____</p> <p>Bronchitis _____ Mastitis _____</p> <p>Cancer _____ Nephritis _____</p> <p>Conjunctivitis _____ Oesophagitis _____</p> <p>Crohn's disease _____ Otitis media _____</p> <p>Cystitis _____ Pancreatitis _____</p> <p>Dermatitis _____ Pelvic inflammation _____</p> <p>Diverticulitis _____ Prostatitis _____</p> <p>Eczema _____ Psoriasis _____</p> <p>Food allergy _____ Rhinitis _____</p> <p>Food intolerance _____ Sinusitis _____</p> <p>Gastritis _____ SLE _____</p> <p>Gingivitis _____ Ulcers _____</p> <p>Hayfever _____ Urethritis _____</p> <p>Heart disease _____</p> <p>Herpes _____</p> <p>Hepatitis _____</p> <p>Hives _____</p>
<p>PRACTITIONER COMMENTS</p>	<p>PRACTITIONER COMMENTS</p>	
<p><b>Toxic Load</b>    <b>CH/M = current high/moderate</b> <b>RPH/M = recent past high/moderate</b> <b>PH/M = past high/moderate</b></p> <p>Alcohol _____</p> <p>Allergies _____</p> <p>Caffeine _____</p> <p>Cannabis _____</p> <p>Copper water pipes _____</p> <p>Drink tap water _____</p> <p>Electrical exposure _____</p> <p>Exercise in polluted areas _____</p> <p>Exercise levels _____</p> <p>Exposure to moulds _____</p> <p>Food additives _____</p> <p>Food pesticides _____</p> <p>Food preservatives _____</p>	<p>Home decorating _____</p> <p>Home gardening _____</p> <p>In heavy traffic _____</p> <p>Infections _____</p> <p>Inflammatory disorders _____</p> <p>Intake of oily fish _____</p> <p>Lead water pipes _____</p> <p>Live in a city area _____</p> <p>Live near pylons _____</p> <p>Live on a farm _____</p> <p>Mercury fillings _____</p> <p>Play golf _____</p> <p>Processed foods _____</p> <p>Unwashed fruit/vegetables _____</p> <p>Smoker _____</p> <p>Work with paints/chemicals _____</p> <p>Live in 'smoky' environment _____</p> <p>Work in 'smoky' environment _____</p>	<p><b>Detoxification</b>    <b>C = current</b> <b>RP = recent</b>      <b>P = past</b></p> <p>Athletes foot _____</p> <p>Caffeine keeps you awake _____</p> <p>Cellulite _____</p> <p>Chronic headaches _____</p> <p>Coated tongue _____</p> <p>Dark under eyes _____</p> <p>Dark urine _____</p> <p>Dehydration _____</p> <p>Feeling of hangover _____</p> <p>Fluctuating mood _____</p> <p>Fluctuating weight _____</p> <p>Itching _____</p> <p>Lethargy _____</p> <p>Muscle aches _____</p> <p>Offensive breath _____</p> <p>Offensive body odour _____</p> <p>Offensive urine _____</p> <p>Premature ageing _____</p> <p>Regularly dieting _____</p> <p>Verrucae/warts _____</p> <p>Water retention _____</p> <p>Worse in damp weather _____</p> <p>Yellow discolouration skin/eyes _____</p>
<p>PRACTITIONER COMMENTS</p>	<p>PRACTITIONER COMMENTS</p>	



HORMONAL HISTORY - WOMEN ONLY		Yes = Y	No = N	SYMPTOMS	
				C = current	RP = recent past P = past
Are you currently pregnant?	___ Regular well-woman checks?	___	___	<b>WOMEN</b>	<b>MEN</b>
Planning a pregnancy?	___ Do you / have you an IUD fitted?	___	___	Breast lumps	___ Altered urine flow
Any problems conceiving?	___ Currently use the contraceptive pill?	___	___	Irregular periods	___ Enlarged prostate
Any acilitated conception/s?	___ Currently use HRT (synthetic)?	___	___	Mastitis	___ Hormone cancer
Any complications in pregnancy?	___ Currently use natural hormones?	___	___	Painful intercourse	___ Impotence
Any history of miscarriage?	___ Any indication of osteoporosis?	___	___	Painful periods	___ Infertility
Any complications in labour?	___ Any history of low thyroid function?	___	___	PMS	___ Minimal shaving
Any premature births?	___ Any history of high thyroid function?	___	___	Heavy periods	___ Low sperm count
Normal deliveries?	___ Any history of polycystic ovaries?	___	___	Hot flushes	___ Low sperm motility
Have you experienced a stillbirth?	___ Any history of fibroids?	___	___	Scant periods	___ Prostatitis
Did you breast-feed?	___ Any history of endometriosis?	___	___	Vaginal bleeding	___
Any problems breast-feeding?	___ Any history of hormone cancer?	___	___	Vaginal discharge	___
				Vaginal dryness	___

**GENERAL SYMPTOMS**  
(associated with regulatory systems)  
C = current RP = recent past P = past

- Abdominal weight gain \_\_\_
- Acne \_\_\_
- Addicted to foods \_\_\_
- Addicted to stimulants \_\_\_
- All boy family \_\_\_
- All girl family \_\_\_
- Better after exercise \_\_\_
- Cataracts \_\_\_
- Carry weight hips and thighs \_\_\_
- Carry weight back and shoulders \_\_\_
- Coarse hair \_\_\_
- Coarse skin \_\_\_
- Cold extremities \_\_\_
- Clammy skin \_\_\_
- Clumsy \_\_\_
- Crave sweet food \_\_\_
- Cry easily \_\_\_
- Difficulty gaining weight \_\_\_
- Dry skin \_\_\_
- Excessive body hair \_\_\_
- Excessive salivation \_\_\_
- Excessive sweating \_\_\_
- Faint without regular food \_\_\_
- Fast metabolism \_\_\_
- Feel cold \_\_\_
- Feel hot \_\_\_
- Food cravings \_\_\_
- Fluctuating weight \_\_\_
- Fractures \_\_\_
- Glaucoma \_\_\_
- Good appetite \_\_\_
- Good teeth \_\_\_
- Good pain tolerance \_\_\_
- Hair loss \_\_\_
- Hair growth \_\_\_
- High pain threshold \_\_\_
- High sex drive \_\_\_
- Kidney stones \_\_\_
- Little body hair \_\_\_
- Long fingers and toes \_\_\_
- Low pain threshold \_\_\_
- Low sex drive \_\_\_
- Loss of hair colour \_\_\_
- Low protein intake \_\_\_
- Macular degeneration \_\_\_
- Morning nausea \_\_\_
- Need to eat regularly \_\_\_
- Palpitations \_\_\_
- Pale skin \_\_\_
- Poor appetite \_\_\_
- Prone to dental decay \_\_\_
- Protruding eyes \_\_\_
- Receding gums \_\_\_
- Reduced sweating \_\_\_
- Referred itches \_\_\_
- Sexually transmitted infection \_\_\_
- Short fingers and toes \_\_\_
- Swollen neck \_\_\_
- Tired after eating \_\_\_
- Weight loss \_\_\_

**PRACTITIONER COMMENTS**

**KEY OBSERVABLE SIGNS & SYMPTOMS OF POTENTIAL NUTRIENT DEFICIENCIES (to be taken into account alongside other factors)**

C = current    RP = recent past    P = past

Acne _____	Dermatitis _____	Brittle nails _____	<b>CLINIC OBSERVATIONS</b>
Bumps on skin _____	Eczema _____	Dandruff _____	
Burning eyes _____	Grooved tongue _____	Dry skin _____	
Cataracts _____	Painful gums _____	Eczema _____	
Dry eyes _____	Red tip of tongue _____	Hair loss _____	
Dry hair _____	Red tongue _____	Pallor _____	
Dry skin _____	Raw tongue _____	Scaly skin _____	
Dull hair _____	Scaly skin _____	Shiny/glossy tongue _____	
Itchy eyes _____	Shiny/glossy tongue _____	EFA _____	
Inflamed eyelids _____	Smooth tongue _____	Hair breaks easily _____	
Peeling nails _____	Sore mouth _____	Poor growth _____	<b>Zinc Taste</b> Mild / Moderate / Strong
Poor night vision _____	Swollen mouth _____	Poor muscle mass _____	
Rigid nails _____	Tooth decay _____	Water retention _____	<b>Blood Pressure</b>
Rough skin _____	B3 _____	Slow wound healing _____	
Thickened skin _____	Burning feet _____	Split nails _____	<b>Ragland Blood Pressure</b>
Tired eyes _____	Eczema _____	Prot _____	
Ulcers _____	Hair loss _____	Constipation _____	<b>Pupil Reaction</b>
A _____	Painful tongue _____	Hair loss _____	
Bleeding gums _____	Teeth grinding _____	Inflamed tongue _____	
Gingivitis _____	B5 _____	Lustreless hair _____	
Easy bruising _____	Acne _____	Pallor _____	
Enlarged veins under tongue _____	Cracks at corners of mouth _____	Poor skin tone _____	
Pallor _____	Dermatitis _____	Spoon shaped nails _____	
Red pimples on skin _____	Eczema _____	Vertical ridged nails _____	
Short of breath _____	Flaky skin _____	Weakness _____	
Slow wound healing _____	Hair loss _____	Shiny/glossy tongue _____	
Thread veins _____	Oily skin _____	Short of breath _____	<b>BMI</b> <b>Waist:hip ratio</b>
Varicose veins _____	Painful tongue _____	Fe _____	
C _____	Pallor _____	Acne _____	<b>Waist:wrist ratio</b>
Pallor _____	Shiny/glossy tongue _____	Bumps on skin _____	
Slow wound healing _____	Short of breath _____	Dandruff _____	
Shortness of breath _____	Water retention _____	Dry skin _____	
Excess wrinkles for age _____	B6 _____	Hair loss _____	
E _____	Difficulty walking _____	Oily hair _____	
Cracked lips _____	Ulcers _____	Poor appetite _____	
Short of breath _____	Pallor _____	Poor night vision _____	
Split nails _____	Raw tongue _____	Poor smell _____	
Water retention _____	Red tongue _____	Poor taste _____	
Cracks at corners of mouth _____	Red tip of tongue _____	Premature grey hair _____	<b>Temperature</b> <b>Pulse</b> <b>Respiration</b>
Hair loss _____	Shiny/glossy tongue _____	Slow growth _____	
Painful tongue _____	Short of breath _____	Slow wound healing _____	<b>Blood Group</b>
Purplish tongue _____	Smooth tongue _____	Short of breath _____	
Shiny/glossy tongue _____	B12 _____	Stretch marks _____	<b>Prior Test Results</b>
Crusty eyes _____	Cracks at corners of mouth _____	Ulcers _____	
Dermatitis _____	Raw tongue _____	White flecks on nails _____	<b>Zn</b>
Loss of eyebrows _____	Red tongue _____	Excess wrinkles for age _____	
Scaly skin _____	Painful tongue _____	Lax joints _____	
Watery eyes _____	Pallor _____	Pallor _____	
B1 _____	Scaling lips _____	Reduced skin pigment _____	
Constipation _____	Short of breath _____	Shortness of breath _____	
Dry eyes _____	Smooth tongue _____	Skin sores _____	
Dry hair _____	Fol _____	Weakness _____	
Dry mouth _____	Constipation _____	AO _____	
Dry skin _____	Dry hair _____	Brittle nails _____	
Dry vagina _____	Dry skin _____	Eczema _____	
Eczema _____	Leathery skin _____	Leg cramps _____	
Excess thirst _____	Swollen neck _____	Muscle spasms _____	
Lifeless hair _____	Voice deepened _____	Poor growth _____	
Rough skin _____	Weight gain _____	Tooth decay _____	
Slow wound healing _____	I _____	C/M _____	
Ulcers _____	Difficulty hearing _____	Food cravings _____	<b>URINE</b>
B2 _____	Difficulty walking _____	Obese _____	
Dandruff _____	Numbness _____	Weight gain _____	<b>STOOL</b>
Loose skin _____	Premature ageing _____	Cr _____	
Premature ageing _____	Sore knees _____		<b>SALIVA</b>
Bio _____	Mn _____		
			<b>BLOOD</b>
			<b>HAIR/SWEAT</b>

**PRACTITIONER RATIONALE**

