Detailed Questionnaire

NAME:

ADDRESS:

HOME TEL: WORKS TEL

MOBILE:

D.O.B. PLACE OF BIRTH:

TIME OF BIRTH:

MARITAL STATUS: NO.OF DEPENDENTS:

YOUR CURRENT PICTURE

APPEARANCE

Height

Weight

Colour of eyes

Colour of hair

Hair condition (circle those appropriate & add any comments)

Oily Normal Dry Split Fine
Thick Thinning Strong Weak

Shape (please circle) Add comments if shape has changed

Apple (thicker around middle)
Pear (thicker around hips
Hour glass (balanced)
Other

Scalp condition (please circle)

Itchy Dry Normal Flaky Oily
Spotty

Skin condition (please circle and add comments re frequency, triggers & location of outbreaks below)

Smooth Dry Oily Flaky Itchy
Eczema Psoriasis

Nails condition (please circle) Strong Weak Brittle Split
Pitted Dotted Ridged

Number of amalgam fillings

Date(s) of fillings

Gum condition (please circle) Good Receding
Prone to infection

Mouth Ulcer occurrence (please circle & list any known triggers below) Frequent Occasional Never

GENERAL LIFESTYLE

Do you drink alcohol Y / N

If yes, how many units per week
(one unit = 1 small glass wine, half pint of beer, 1 measure of spirit)

Please circle the following wheat-based products you eat weekly: Bread Pasta Biscuits
Cake Cous-Cous Pizza

Please circle the following dairy products you eat weekly: Milk Cheese Butter
Cream Yoghurt

How many cups of tea do you drink daily?

How many cups of coffee do you drink daily?

How many cans of soft drinks do you drink daily / weekly?

Do you take 20 mins of exercise 3 times weekly? If yes, please state what types & if you find them enjoyable. Y / N

Do you smoke? Y / N

For how long have you smoked?

How many cigarettes do you smoke daily?

How much do you spend on cigarettes weekly?

Do you like the taste of cigarettes? Y /N

Do you really want to give up? If yes, then please state why Y /N

Do you reach for a cigarette when : (please circle relevant options) stressed tired with alcohol bored had a meal upset coffee / tea on waking

SLEEP / CONCENTRATION PATTERNS

Have you made a connection with moon cycles and your sleep pattern? Y / N

Do you get to sleep easily? Y /N

How many hours sleep do you average?

Do you have restless sleep? (Add comments below) Y /N

Do you wake up feeling tired? (Add comments below) Y /N

Do you have trouble sleeping on your right side? Y /N

Do you grind your teeth at night? Y /N

Do you dribble at night? Y /N

Do you feel tired of an afternoon? (Add comments below) Y /N

Do you wake up at a regular time each night? State reason if known Y / N

What is your concentration like? (please circle) Poor Fair Good Excellent

What is your motivation like? (please circle) Poor Fair Good Excellent

Do you snore? Y / N

Do you talk in your sleep? Y / N

What is your creativity like? (please circle) Poor Fair Good Excellent

What is your short term memory like? (please circle) Poor Fair Good Excellent

MENOPAUSE / MENSTRUATION (women to complete)

Do you still menstruate? Y /N

State regularity of your periods

Do you have intermittent menstruation? (Add comments below) Y /N

Do you have any pain? Y /N

What flow best describes your period?

- Heavy at first, but then light
- Heavy the whole time
- Light the whole time
- Intermittent bleeding
- Clotting
- Other (please give details)

For how many days do you menstruate?

Are you on HRT? Y /N

If yes, how long have you been taking it?

Do you have hot flushes? Y /N

If yes, how many daily / nightly?

Describe any aches & pains which accompany your period

DIGESTIVE HABITS

Do you suffer from indigestion? Y /N

Do you know if you are intolerant to certain foods? Please list below Y /N

Do you have reflux problems? Y /N

Do you skip meals? If yes, which meal. Y /N

Do you eat after 8pm on a regular basis? Y /N

How many bowel movements do you have daily / weekly?

Do you suffer from Irritable Bowel Syndrome ? Y /N
(alternating diarrhoea and constipation). Describe triggers – if known

What best describes your stools? (please circle)
Light Medium Brown Dark
Sticky Pellets Well-Formed
Float Sink Smelly Explosive

How many times do you urinate at night?

Do you have problems with urination e.g. weak bladder? Y / N
(If yes, please state here)

How many times do you urinate daily?

What colour is your urine? (Please circle) Light Dark Orange Other

MEDICAL STATUS

GP NAME:

SURGERY NAME & ADDRESS:

SURGERY TEL.NO:

Are you currently on any medication? Y /N
If yes, please list their names and the condition they are for:

Do you have sinus problems ? (Add comments below) Y / N

Do you suffer with headaches? State frequency, location & triggers Y / N

Do you suffer with migraines? State frequency & triggers Y / N

Do you have verrucas? Y /N

Do you suffer from eczema or psoriasis? State frequency & triggers + location of where it is worse. Y /N

Do you have dandruff? Y /N

Do you suffer from piles? Y /N

Do you have a fungal infection on the feet or toes? Y / N

Do you have achy hips? Y / N

Do you have achy knees? Y / N

Do you wear glasses? If yes, state date / age started Y / N

Do you have any ENT problems? If yes, please list frequency & triggers Y / N

Do you take any supplements? If yes, please list below: Y /N

STRESS (please circle an option)

Do you feel stressed?	Never	Occasionally	Often
Do you have mood swings?	Never	Occasionally	Often
Do you get irritated easily?	Never	Occasionally	Often
Do you find it difficult to "switch off" of an evening?	Never	Occasionally	Often
Do you cry easily?	Never	Occasionally	Often
Do you reach for food when stressed?	Never	Occasionally	Often
If yes, which food(s)			
Do you feel depressed?	Never	Occasionally	Often
Are you apathetic (Can't be bothered with anything)?	Never	Occasionally	Often
Do you feel tired upon awakening ?	Never	Occasionally	Often

How would you assess your tiredness level: (circle one option) Add comments below:

Fatigued (have to lie down often)
Bad (struggle to get through the day)
Medium (cope with the day, but look forward to bedtime)
Fair (generally have good energy, but get tired in the afternoon)
Good (no problems - rarely feel tired)

STRUCTURAL

Do you have any joint pain? If yes, which joints? Y /N

Do you have any muscle pain? If yes, which muscles? Y /N

Do you have arthritis? Y /N

Do you have rheumatism? Y / N

Do you have inflammation of joints or muscles? Y /N

If yes, please describe:

YOURSELF AGE 0 – 12 YEARS	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, teething problems, illnesses, operations, bone breakages / fractures, medications, ENT.	
Place of birth…… …… Date of birth…… Time of birth…… Mother's age at birth……. Natural / Caesarian birth…… Your place in sibling group e.g. 2nd child of 6……	

YOURSELF – TEENAGE YEARS	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

YOURSELF – 20S	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

YOURSELF – 30S	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

YOURSELF – 40S	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

YOURSELF – 50S	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

YOURSELF - 60S	**NOTES**
Include all vaccinations, constipation / diarrhoea, colic, milk intolerance, mucus problems,skin outbreaks, whooping cough, breathing difficulties, sleep patterns (good / bad), food dislikes, behavioural problems, illnesses, operations, bone breakages / fractures, medications, drugs, alcohol, depression, eating disorders, ENT, menstrual history, places of travel & duration.	

MOTHER HISTORY	**MATERNAL GRANDPARENTS HISTORY**	**NOTES**
Please include all medical background as well as behavioural conditions e.g. workaholic, eating disorders, tidiness compulsion etc. Inc skin conditions, allergies etc. State age & year if known.		

FATHER HISTORY	**PATERNAL GRANDPARENTS HISTORY**	**NOTES**
Please include all medical background as well as behavioural conditions e.g. workaholic, eating disorders, tidiness compulsion etc. Inc skin conditions, allergies etc. State age & year if known.		

YOUR SIBLINGS HISTORY	**MATERNAL / PATERNAL SIBLINGS HISTORY**	**NOTES**
Please include all medical background as well as behavioural conditions e.g. workaholic, eating disorders, tidiness compulsion etc. Inc skin conditions, allergies etc. State age & year if known.		

DIETARY DETAILS		**COMMENTS**
CURRENT DIET: BREAKFAST: LUNCH: DINNER: SNACKS: No.of litres of filtered water drank daily……..…….. No of teas drank daily…… No. of coffees drank daily……. No. of sodas drank daily…… No of herbal teas drank daily……..…….. **DIETARY CHANGES**: ADD IN: AVOID:		
