SIMPLY HEALTH

CLINICAL PRACTICE

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STRICTLY CONFIDENTIAL: HEALTH SYSTEMS QUESTIONNAIRE:

Do you suffer with any of the following health conditions (please circle where applicable and feel free to make any notes you think relevant):

HEAD: Headaches, Migraine, Dizziness, Fainting.

SKIN, HAIR, SCALP, NAILS: Acne, Eczema, Psoriasis, Other Rashes, Hair Loss, Dandruff, Excess Sweating.

EYES: Eyestrain, Light Sensitivity, Blurred or Double Vision, Watering.

EARS, NOSE & THROAT: Deafness, Ear Noises, Wax accumulation, Earaches, Sinusitis, Loss of sense of Smell, Blocked nose, Frequent colds, Hay fever, Allergies, Catarrh, Sneezing, Swollen Glands, Infections, Nosebleeds.

MOUTH, TEETH & GUMS: Toothache, Lost or Loose Teeth, Abscesses, Ulcers, Cold Sores, Mercury Fillings, Bleeding Gums, Grinding Teeth, Taste Disorders.

NECK, SHOULDERS & ARMS: Aching, Tension, Arm Pain, Tingling, Cold Hands, Joint Pains.

CHEST: Pains, Tightness, Breathing Difficulty, Coughs, Wheezing, Palpitations.

DIGESTIVE SYSTEM: Acidity, Burning, Bleeding, Wind Up or Down, Indigestion, Nausea, Vomiting, Bloating, Constipation, Diarrhoea, Haemorrhoids, Fissures, Change of stool colour.

URINARY SYSTEM: Thirst, Frequency day or night, Burning, Infections, Restricted flow, change in urine colour or smell.

FEMALE SYSTEM: Menstrual Irregularities, Cramps, PMT, Menopause, Hot Flushes, Loss of Libido, Discharges, Infections, Infertility, Breast Lumps or Tenderness.

MALE SYSTEM: Erection problems, Loss of Libido, Infections, Lumps, Discharges, Infertility.

BACK, HIPS & LEGS: Low Back Pain, Sciatica, Joint Pains, Pins & Needles, Varicose Veins & Eczema, Swollen Ankles, Cold Feet.

NERVOUS SYSTEM: Weakness, Poor Co-ordination, Memory Loss, Difficulty Concentration, Numbness, Coldness.

MISCELLANEOUS: Thyroid Dysfunction, Cancer, HIV, Blood Pressure, Blood

Sugar Issues, Other (please list).

DIETARY EVALUATION OF A TYPICAL DAY
Please make a note of all food and drink consumed during a single day.

	Time	Food & Drink Consumed
Breakfast		
Mid morning		
Lunch		
Afternoon		
Dinner		
On Retiring		

Please answer the following and provide details of your answer where applicable:

Do you have any specific dietary requirements? (Y / N)

Have you experienced any weight loss or weight gain recently? (Y / N)

Do you frequently skip meals? (Y / N)

Do you have a healthy appetite? (Y / N) Do you add the

following to your food / drink? Salt: ____Sugar: ____Sweetener:

How many cups/glasses do you consume daily? Tea: __Coffee _____ Sweet fizzy drinks: Water: __ Milk: __________ (please specify type eg skimmed, soy etc) _________________

Weekly intake of Alcohol: Beer (pints):__ Wine (bottles)___Spirits (shots): _____

Do you use mainly: Butter / Margarine **What is the main oil you use for cooking? Food quality & type: Please give estimated % of the following quantities of food:**

How much of your food is: Prepared at home:__Takeaway: ___ Restaurant:____Sandwich shop:

How much of the food you cook with is: Fresh: ___ Frozen: ___Tinned: ____Pre-cooked:___(for microwave)

How much of your fresh vegetables are: Organic:___Unprepared: ____Supermarket prepared: ____

How much of your food you eat at home is: Raw (salads etc):____Cooked: ______ **How much of the cooked food is:** Boiled:_ _Baked:_ _Stir Fried _ Deep Fried:_ Micro'd:__ Steamed__

Known food allergies/intolerances:

With Thanks
Paula Myrie – Naturopathic Medical Physician.