



Confidential Health Questionnaire

Name:Mr/Mrs/Miss/Ms/.....

Date of Birth:Age:.....

Address:

Marital Status:

.....

No/Age of Children:

.....

Home no:.....

.....

Mobile no:.....

Postcode:

Occupation:

Email:.....

Doctor's name:.....

Where did you hear about us:.....

May we speak to your Doctor if needed Yes/ No

To enable us to gain a holistic view of your health, please indicate if you have any of the following symptoms. (Within this year)

Please tick: ✓ Occasional (every 6 months) ✓✓ Often (more than once a month)

GENERAL

- Headache / Migraines
- Fever, Chills
- Fainting
- Dizziness
- Convulsions
- Loss of sleep
- Fatigue
- Nervousness
- Weight loss / gain
- Numbness/pain arms/legs
- Wheezing
- Neuralgia
- Thirsty/Dry Mouth-

EAR, NOSE, THROAT

- Failing vision / Squint
- Deafness
- Earache / Ear noises
- Ear discharges
- Nose bleeds
- Nasal obstruction
- Sore throat / hoarseness
- Asthma
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sinus infection
- Enlarged glands
- Hay fever

SKIN

- Skin eruptions
- Itching
- Bruise easily
- Dryness
- Boils / Acne
- Varicose veins
- Sensitive skin
- Hives or allergy
- Shingles

Athletes foot

Psoriasis

Eczema

RESPIRATORY

- Chronic cough
- Dry chesty cough
- Productive cough
- Spitting up phlegm
- Spitting up blood
- Chest pain

CARDIOVASCULAR

- Irregular heartbeat
- Blood Pressure High / Low
- Pain over heart
- Previous heart attack/stroke
- Hardening of arteries
- Swelling of ankles
- Poor circulation
- Blood clots

MUSCULOSKELETAL

- Stiff neck
- Backache
- Shoulder trouble
- Painful elbow
- Wrist trouble
- Jaw joint trouble
- Knee problems
- Hip joint problems
- Swollen joints
- Painful tailbone
- Foot trouble
- Sciatica

GENITOURINARY

- Frequent urination
- Painful urination
- Urine discoloration
- Blood in urine
- Kidney infection or stones
- Bed wetting

Inability to control urine

Prostate concerns

GASTROINTESTINAL

- Poor appetite
- Excessive hunger
- Difficult digestion
- Belching / gas / flatulence
- Nausea / Vomiting
- Heartburn
- Vomiting blood
- Pain over stomach
- Abdomen distension
- Constipation
- Diarrhoea
- Haemorrhoid (piles)
- Intestinal worms
- Liver trouble
- Gall bladder trouble
- Jaundice
- Colitis/Crohns disease
- Coeliac disease

WOMEN ONLY

- Painful menstrual problems
- Excessive flow
- Hot flushes
- Irregular cycle
- Cramps or backache
- Previous miscarriage
- Vaginal discharge
- Congested breast
- Lumps in breast
- Menopausal problems
- PMS

PLEASE SPECIFY OR DELETE WHEN THE QUESTION IS DUAL IE, HEADACHE/MIGRAINE

If you have had any of the following diseases, please tick

Appendicitis
Pneumonia
Rheumatic fever
Pleurisy
Tuberculosis (TB)
Alcoholism

Arthritis
Venereal disease
Epilepsy
Mental disorder
Gastric ulcers
Anaemia

Hepatitis
Herpes
Diabetes
AIDS
Thyroid
Cancer

Heart disease
Glandular fever
Thrush
Cystitis

Please describe your main health concern?

Do you have a history of using Antibiotics, Steroids, Anti depressants, Oral Contraceptive Pill, or other medication? Yes / No
If Yes, please circle and give details

Do you have a history of reoccurring Thrush or Cystitis. Yes/ No
If Yes, please circle and give details

Please circle if you regularly eat the following foods:

WATER	RED MEAT	WHITE MEAT	FISH	SOY	DAIRY	WHEAT	FRUITS	LEGUMES
VEGES	COFFEE	TEA	ALCOHOL	COKE	SUGAR	SWEETENERS	HERBAL TEAS	TAKE AWAYS

Please circle if you are a Vegan or Vegetarian.

Do you avoid any particular food for specific reasons, eg religion?

Are you a smoker? _____ Number of cigarettes a day? _____ Number of years? _____

Is there anything else relating to your health that has not been covered?

Signature:

Date: