Health Check Questionnaire

All details on this questionnaire will be held private and confidential. The more complete your information, the more we can help you.

Date completed:_____

PERSONAL DETAILS

Surname: …… First name: ……Marital status:……

Contact address: ……

……

Email:……..Contact tel no: ……

Occupation: [type: office/ sedentary/ movement / retail / 'on the go' etc]……

Date of birth: …… Height: …… Weight: ……..

No. of dependents: …… Age/sex of children: ……..

GP Name: ……

Can you include medical records with this questionnaire: ……

Do you give permission for your medical doctor to be contacted? ☐ *tick for yes* ……

Are you currently following a medically prescribed diet? ☐ ……..

Are you currently undergoing medical treatment? ☐ ……..

Are you pregnant, or aiming to become pregnant?* ☐ ……..

Do you have a medically identified food allergy or intolerance? ☐ ……..

HEATH GOALS

Are there any specific goals that you are looking to address?

1. ……
2. ……
3. ……

PERSONAL HEALTH HISTORY

Please list all significant health problems from which you have suffered, starting with the most recent, continuing on a separate sheet if necessary

Health Problem	Duration	Management	Date
EXAMPLE: migraines abdominal pain	 20 years 2 years	 Migrileve Paracetamol Appendectomy	 1976-current 1966-1968 1968
1……	……	……	……
2……	……	……	……
3……	……	……	……
4……	……	……	……
5……	……	……	……
6……	……	……	……
7……	……	……	……

MEDICATIONS & SUPPLEMENTS

Please list below any prescribed drugs - current or in the past, using a separate sheet if necessary

*** Please note that some of the supplements we recommend are not suitable if you are pregnant or planning to become pregnant. By signing this form you are confirming that this is not the case.**

Prescribed / Over the counter Medication	Dose	Condition being treated	Frequency	Duration	current	past
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
Supplement/Herb	Dose	Condition being treated	Frequency	Duration	current	past
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐
……	……	……	……	……	☐	☐

HEREDITY PROFILE

Is there any history of health problems or disease in your family?	**Tick for yes**	**Comments**
Grandparents	☐	……
Parents	☐	……
Brothers/sisters	☐	……
Children	☐	……

ALLERGY PROFILE

Do any of the following apply?	**Tick for yes**	**Comments**
☐Family history of allergies		……
☐Diagnosed allergy		……
☐History of a severe allergic reaction/anaphylactic shock		……
☐Been tested for allergies		……

Please list any foods and/or chemicals that you react to: ……

LIFESTYLE AND SYSTEM PROFILES

Please tick the boxes that apply to you

Digestion/Elimination Profile
☐bloating/flatulence
☐don't chew food properly
☐can't tolerate fatty meals
☐heartburn/reflux
☐indigestion
☐pain under right rib-cage
☐pain under right shoulder-blade
☐anal irritation
☐blood/black stool
☐constipation
☐diarrhoea
☐haemorrhoids
☐mucus or pus in stool
☐has foreign travel resulted in digestive problems

Sleep/Energy Profile
☐ disordered sleeping pattern
☐ difficulty getting to sleep
☐ difficulty getting/waking up
☐ feel un-refreshed after sleep
☐ fatigue
☐ fluctuating energy

Toxic Load Profile
☐caffeine keeps you awake
☐drug use including recreational
☐exercise by busy main roads
☐a lot of time in-front of TV/VDU
☐exposure to domestic moulds
☐unwashed fruit and vegetables
☐eat non-organic produce
☐usually drink tap water
☐smoke cigarettes
☐regular alcohol consumption
☐headaches
☐mercury fillings
☐muscle / joint aches
☐offensive breath / body odour
☐dark coloured urine
☐dark circles under the eyes
☐yellowing of skin/eyes

Immunity Profile
☐coated tongue
☐regular colds/infections
☐nail infections
☐sensitivity to chemicals
☐signs of premature ageing
☐thrush/cystitis/athletes foot
☐verruca/warts
☐frequent ulcers
☐traveller's diarrhoea
☐unexplained itching/rashes
☐antibiotics on a yearly basis
☐hayfever/rhinitis
☐suffer from allergies
☐growths or lumps biopsied

Mood Profile
☐ aggression/anger
☐ anxiety/tension
☐ apathetic/lethargic
☐ depression
☐ hyperactive
☐ irritability
☐ mood swings

Adrenal/Blood Glucose Profile
☐blurred vision
☐excessive thirst &/or urination
☐fluctuating energy
☐impotence/lack of sex drive
☐low blood pressure
☐nausea without food
☐palpitations
☐panic attacks
☐poor memory/concentration
☐tired, particularly after lunch
☐need tea/coffee/cigarette/sugar to wake up in morning
☐need tea/coffee/cigarettes/sugar at regular intervals
☐dizzy/irritable without regular food

Stress Profile
☐easily angered/irritated
☐excessive exercise
☐always multi-tasking
☐feel mentally dull
☐shift worker
☐stressful job
☐difficulty getting to sleep
☐feel guilty when relaxing
☐get impatient easily
☐unclear about goals
☐unhappy at home
☐unhappy at work
☐recent change in life that has increased stress *please state*
……

Cardiovascular/Circulatory Profile
☐blue extremities
☐calf pain
☐chest pain
☐feel cold/hot
☐feel faint on standing
☐feel stressed
☐groin pain
☐high blood pressure
☐high cholesterol / triglycerides
☐high fat/sugar diet
☐nose bleeds

Female Hormonal Profile (women only)
Age at first period: _____ Age at final period: _____

☐do you have regular well-woman check-ups?
☐do you, or have you had an IUD fitted?
☐do you, or have you taken the contraceptive pill?
☐do you, or have you taken HRT/natural HRT?
☐have you experienced difficulty conceiving?
☐have you experienced a miscarriage/stillbirth?
☐have you had a hysterectomy?
☐dry hair/skin
☐acne
☐excessive hair growth
☐hair loss
☐heavy/painful periods
☐history of anorexia
☐hot flushes
☐irregular periods
☐feel cold
☐low sex drive
☐PMS
☐protruding eyes
☐swollen neck/goitre
☐water retention

Male Hormonal Profile (men only)
☐acne
☐altered urine flow
☐coarse hair
☐cold extremities
☐depression
☐diminished sweating
☐dry hair / skin
☐excessive sweating
☐feel cold
☐impotence / low sex drive
☐infertility
☐protruding eyes
☐swollen neck/goitre
☐wake up to go to the toilet

Exercise Profile
Are you: ☐ Active?* ☐ Moderately active?* ☐ Sedentary? **please list your activities below*
☐Do you enjoy exercise? ☐Does your job/hobby involve exercise? (eg. gardening)
☐If you do not participate in regular exercise, what factors prevent you from doing so?
……

Type of exercise	Frequency	Duration	Place
.....	.....	.....	.....

DIETARY ANALYSIS

Are there any foods that you crave? .....
Are there any foods that you dislike? .....
What are your favourite foods? .....
Which foods would you find hard to give up? .....
Are you following a special diet, now or in the past? .....

Do you

- ☐ or have you experienced an eating disorder?
- ☐ cater for a special diet in the family?
- ☐ eat lots of wheat and dairy products?
- ☐ eat out frequently?
- ☐ Is your diet repetitive?
- ☐ cook for more than one?
- ☐ enjoy eating and preparing food?
- ☐ have a good appetite?
- ☐ mainly purchase organic produce?
- ☐ Have you recently changed your diet?
- ☐ Is shopping easy for you?

How Many

biscuits in a week?	.....	glasses of water a day?	.....	**Do you**
cakes/pastries in a week?	.....	portions of oily fish per week? (salmon, mackerel, anchovies, sardines, fresh tuna, herring, trout, pilchards, kippers)	.....	☐ add salt to cooking or food?
cups of coffee a day?	.....			☐ add sugar to food or drink?
cups of tea a day?	.....			☐ drink decaffeinated tea or coffee?
cups of herbal tea a day?	.....	cigarettes a week?	.....	☐ regularly eat fried food?
pints of milk a week?	.....	Units of alcohol a week? (1 unit = 1 small glass of wine, ½ pint of beer, 25ml of spirit)	.....	☐ regularly eat processed food?
slices of bread in a day?	.....			☐ regularly eat ready prepared meals?
chocolate in a week?	.....			☐ regularly microwave food?
				☐ avoid additives and preservatives?

What

Oil do you use to cook with..... ...
Do you spread on bread etc..... ...

Do you

- ☐ choose mainly low-fat food?
- ☐ eat takeaways more than once per week?
- ☐ eat mainly wholegrain bread, rice, pasta & cereals?

FOOD DIARY Please list all foods & drinks you would normally eat on an average weekday or weekend

Typical Weekday

Breakfast Time .....
.....
.....
.....
.....
Lunch Time .....
.....
.....
.....
.....
.....
Dinner Time .....
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.....
Snacks/Treats Times of .....
.....
.....
.....
Drinks
.....
.....

Typical Weekend Day

Breakfast Time .....
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Lunch Time .....
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.....
Dinner Time .....
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.....
Snacks/Treats Times of .....
.....
.....
.....
Drinks
.....
.....

Please use this box for additional notes if necessary

I confirm that all information included on this questionnaire is correct to the best of my knowledge.
Signature ……..

Thank you – please bring this form with you to your consultation.
Maev Creaven

ADDITIONAL INFORMATION

Medical Records

Please bring with you any medical reports that have been tested over the last 18 months.

Your Action Plan

Your Personalised Action Plan will be emailed 5-7 days post your consultation.

Cancellation/ Late Arrival Policy

As a courtesy to our team and other clients, if you need to cancel or change an appointment we request a minimum of 48 hours notice. Failure to show for an appointment will result in the full cost of a consultation being charged.

Consultations

All consultations are strictly confidential. Your information is held in accordance with IFM and NTOI rules. Where relevant we may keep your GP and integrative healthcare practitioners informed about your programme, however, only with your permission.