Confidential Health Questionnaire

Name: ……Mr/Mrs/Miss/Ms/…… Date of Birth: ……Age:……

Address: ……..

……..

…….. Home no:……..……

…… Mobile no:……

Postcode: ……

Email:……

Where did you hear about us:……

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	Arthritis	Hepatitis	Heart disease
Pneumonia	Venereal disease	Herpes	Glandular fever
Rheumatic fever	Epilepsy	Diabetes	Thrush
Pleurisy	Mental disorder	AIDS	Cystitis
Tuberculosis (TB)	Gastric ulcers	Thyroid	
Alcoholism	Anaemia	Cancer	

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: …….**