



Study your body's food needs with the world's leading expert

HEALTH QUESTIONNAIRE

CONFIDENTIAL

Forenames

Surname

Date You Joined Us

Marital Status

Sex M F

Occupation

Age

Current Weight

Current Height

Main conditions that trouble you at present	Approx. date of onset

How frequently do symptoms occur?

Have you noticed anything that makes your symptoms worse or better (say which)?

Are you taking any drugs or medications?

Include sleeping tablets, pain killers, antihistamines, blood pressure pills, contraceptive pills, HRT, laxatives, etc.

Are you taking any vitamins, minerals or other nutritional supplements?

List any drug to which you have ever reacted adversely (*include anaesthetics*)

Drug	Symptoms

Personal Medical History

Please list all main conditions, operations, accidents etc. from which you have suffered. Ladies should include also pregnancies, miscarriages and menopause, if relevant.

Year	Illness, Operation, Accident, Pregnancy, Etc.

General Questions

What is your daily consumption of tobacco?

Have you smoked in the past? When you stopped?

What is your daily/weekly consumption of alcohol? (*give details*)

Have you drunk heavily in the past?

How many cups of tea/coffee do you drink daily? Tea Coffee

What do you normally eat for:

Breakfast

Midday meal

Evening meal

Do you have any snacks during the day? If so, give details below

Section A

Do you suffer from:

- Undue fatigue not helped by rest
- Fast beating heart/palpitations
- Bouts of sneezing for no obvious reason during day or night
- Swelling or puffiness of ankles or fingers
- Restless legs
- Overweight or major fluctuations in weight
- Food cravings of any sort
- Headaches
- Feeling particularly bad first thing in the morning
- Feeling much worse if you miss a meal

Section B

- a) Have you taken frequent or long-term antibiotics? How often/how long?
- b) Do antibiotics upset you in any way? Rash? Thrush? Feel generally bad?
- c) Have you ever taken cortisone tablets by mouth?
- d) Do you ever suffer from thrush? (vaginal, oral, penile)
- e) Do you suffer from excessive wind or bloating?
- f) Do you have irritation around the anus at times?
- g) Do you have fungal infections of the skin, such as ringworm or athlete's foot?
- f) Do you crave sugar and sweet foods?
- g) Do alcoholic beverages upset you?
- h) Are you worse in damp weather or old musty surroundings?

Section C. Allergies

1. Do you now or have you ever suffered from any known allergies to anything, either food, fumes, pollens, animal danders, dust, moulds, chemicals, drugs, metals, plasters, soaps, detergents, or anything else? If so what and what symptoms did they produce?
2. Does anyone in your immediate family (parents, brothers, sisters, aunts, uncles, grandparents, cousins or your own children) suffer any known allergies to anything? If so what are they allergic to and what form does it take?
3. Have you ever had asthma, hayfever, eczema, migraine, arthritis, colitis, depression or psychiatric illness?
4. Is there any food or drink you avoid because it disagrees with you?
5. Are your symptoms worse at any particular time of day? Of the month? Of the year?
6. If you normally eat regular meals, what happens if you miss one or more meals?

7. Since your symptoms started or in the last year have you had any of the following:

Red or itchy eyes	Stiffness in throat or tongue	Inability to think clearly (“woolly brain”)
Bronchitis	Water retention	Panic attacks
Asthma	Terrible thoughts on waking	Feeling unreal, depersonalized
Itching	Shaking in the morning	Lack of confidence
Eczema	Slow getting started in the morning	Mood swings
Blotches on the skin	Insomnia	Sudden sneezing
Mouth ulcers	Crabby on waking	High mood (undue elation)
Dyspepsia, abdominal distress, flatulence	Difficulty waking up	Low mood
Abdominal bloating	Abrupt changes of state from well to unwell	Mood swings
Pain the stomach	Rash that isn’t eczema	Menstrual difficulties
Constipation	Aching muscles	General slowing down
Diarrhoea	Swollen painful joints	General speeding up
Variable bowel function	Headache (incl. migraine)	Tingling all over
Unusually slow or rapid heartbeat	Convulsions or fits	Vomiting without nausea
Pain in the chest	ringing in the ears	Sudden tiredness after eating
High blood pressure	Giddiness	Sudden chills after eating
Cramps in limbs	Nausea	Feeling totally drained and exhausted
Chilblains	Frequent urination	Eating binges
Feeling faint	“Dopey” feeling (brain fag)	“Flu-like state” that isn’t flu
Feeling unwell all over	Irritability	Catarrh

Section D. Environment

- i) Does your condition improve if you are on holiday? Away from work? Away from home? (state which)

- ii) Is your home heated by gas or electricity (or both)? Any other source of heat, for example wood stove or fireplace or paraffin heater, etc?

- iii) Do you have an acute nose (you can smell substances when other people can't)? Or have you lost your sense of smell?

- iv) Are you aware of unpleasant reactions to chemicals (or are there chemical smells which you especially like)? Examples: gas, petrol fumes, gloss paint, perfume...

- v) Have you been exposed to chemicals in the form of work exposure or a pollution/ poisoning episode?

- vi) Do you get symptoms on long car journeys? In shopping malls? In carpet or fabric shops?

- vii) Can you pinpoint the onset of your symptoms to one particular event in your life? If so what?

Section E. Females Only

Do you feel worse pre-menstrually, eg. tension, depression, headaches, water retention, breast tenderness?

Have you taken the contraceptive pill? If so, for how long?

Did it upset you when you took it?

Have you taken HRT?

Have you ever suffered from cystitis (frequent passing of urine, associated with a burning sensation)?

THANK YOU FOR COMPLETING THIS FORM