Naturopathic Health Assessment Questionnaire

Please complete as clearly, completely and accurately as possible
(don't worry if there are some details you don't know). Then return,
at least two days before your consultation by e-mail to healthrevisited@aol.com
If you do not have e-mail then please call 07551 327899 to ask where it should be posted.

PRIVATE AND CONFIDENTIAL

Title: ..... First Name: ..... Last Name: .....

Address: .....

..... Post Code: .....

Phone Numbers: ..... Email: .....

Date of Birth: ..... Age: ..... Occupation: .....

Marital status: …….. Children: ……

Is your GP aware you are having nutritional therapy? (Y/N) .....

Do you give your permission for your GP to be contacted? (Y/N) .....

GP's Name: ..... Address: …….....

..... Post Code: .....

GENERAL HEALTH PROFILE

What is your main reason for seeking nutritional advice? .....

List the outstanding health problems you have in the order of importance and indicate how long you have had them (use a separate sheet if necessary):

Health Problem Duration

1. ....
2. ....
3. ....
4. ....
5. ....

Under what circumstances do these problems get worse?: .....

Under what circumstances do they improve?: .....

List any major surgery or significant periods of ill health in your life and any chronic or niggling health problems:

.....

.....

.....

……

……

Give details (date, reason) of any antibiotic use in the past 12 months? .....

……

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Give medications you are currently taking or have taken in the last month:

_____ Antacids
_____ Antibiotics
_____ Anticonvulsants
_____ Antidepressants
_____ Antifungals
_____ Aspirin or Ibuprofen
_____ Asthma inhalers
_____ Beta blockers
_____ Chemotherapy
_____ Cortisone /steroids
_____ Diabetic medications
_____ Diuretics
_____ Estrogen/Progesterone
_____ Heart medications
_____ High blood pressure
_____ Hormone Therapy
_____ Laxatives
_____ Insulin
_____ Oral/implant contraceptives
_____ Radiation exposure
_____ Recreational drugs
_____ Relaxants/Sleeping pills
_____ Thyroid medication
_____ Tylenol/acetaminophen
_____ Ulcer medications

List any prescribed medications you are currently taking (name and dose): ……

……

.....

……

List any vitamins, minerals, herbs or other health supplements you might be taking: ……

……

……

Your weight: ..... Height: ..... Blood Pressure: ..... Pulse Rate: .....

Please scan and attach /or bring with you to the consultation any test results or other investigations you has recently

FAMILY HEALTH PROFILE

If you have any brothers and sisters what illnesses are they prone to? ……

.....

If you have any children what illnesses are they prone to? ……

.....

Do/did your parents or grandparents suffer from any illnesses (e.g. heart disease, diabetes, asthma etc)? Give details:

.....

.....

SYMPTOM ANALYSIS

Please read through the symptoms listed in Personal Vitamin & Mineral Analysis (a separate file or sheet) and place a tick against any that you are presently aware of.

LIFESTYLE ANALYSIS

Please read through the questions below and place a tick against any that apply to you.

Cardiovascular Profile

….. Is your blood pressure above 140/90?
….. Is your pulse after 15 minutes' rest above 75?
….. Are you more than 14lbs (7kg) over your ideal weight?
….. Do you smoke more than 5 cigarettes a day?
….. Do you do less than 2 hours exercise a week?
….. Do you eat more than one spoonful of sugar a day?
….. Do you eat red meat more than 5 times a week?
….. Do you usually add salt to your food?
….. Do you have more than 2 alcoholic drinks a day? ……

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….. Is there a history of heart disease in your family?
….. Do you experience dull pain or tightness in the chest?
……Do you have any chest pain that radiates into the left arm?
……Do you get short of breath easily after light exertion?
……"Air hunger" or yawn frequently?
……Do you have a persistent night cough?
……Are you aware of heart palpitations (rapid heartbeat)?
……Do you have a puffy face or swollen ankles by the end of the day or retain water easily?
……Do you or your parents have varicose veins?
……Are your hands and feet always cold?

Exercise Profile

….. Do you take exercise that noticeably raises your heart rate for 20 minutes more than 3 times a week?
….. Does your job involve vigorous activity?
….. Do you regularly play a sport (football, squash etc)? ……..
….. Do you have any physically tiring hobbies (gardening, cycling etc)? ……
.....How many times a week and how long do you exercise, if at all? ……..
…..How much walking do you do every day? ……
….. Do you consider yourself fit?

Polllution Profile

….. Do you live in a city or by a busy road?
….. Do you spend more than 2 hours a week in traffic?
….. Do you exercise (jog, cycle, play sports) by busy roads?
….. Do you smoke? How many cigarettes a day? ……..
….. Do you live or work in a smoky atmosphere?
….. Do you buy foods exposed to exhaust fumes?
….. Do you generally eat non-organic produce?
….. Do you drink more than 1 unit of alcohol a day?
….. Do you spend a lot of time in front of a TV or PC screen?
……Do you use a microwave oven for your cooking and how often? ……
….. Do you usually drink unfiltered tap water?
……Are you a frequent flyer? How many times a year do you travel by plane? ……..
……Are you exposed to any chemicals in the course of your work (hairdressing, painting, farming, etc.)?
……How many amalgam fillings do you have in your mouth?

Stress Profile

….. Do you tend to be a 'night person'?
……Do you feel guilty when relaxing?
….. Do you have a persistent need for achievement?
….. Are you unclear about your goals in life?
….. Are you especially competitive?
….. Do you work harder than most people?
……Do you work more than 60 hours a week? (usually, occasionally, never) ……
….. Do you easily become angry?
……Have you gone through divorce fairly recently?
……Have you changed jobs within the last year?
……Have you lost any members of the family, close relatives or friends recently? ……..
….. Do you often do 2 or 3 tasks simultaneously?
….. Do you get impatient if people or things hold you up?
….. Do you have difficulty getting to sleep?
….. Do you gain weight predominantly around your abdomen?
……Do you crave salty foods?
……Do you feel wired or jittery when drinking coffee?
……Do you clench or grind your teeth?
….. Do you have dark circles under eyes?
……Do you become dizzy when standing up suddenly?
Rate your stress level on the scale 0 – 10 (10 being the highest): ……

Nervous System Profile

…..Do you suffer from any sleep disturbances (waking at a particular time at night, night sweats, vivid or scary dreams)?

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…..What is your sleep pattern (wake up or fall asleep easily / with difficulty, early, need more than 8 hrs sleep, light or heavy sleeper, etc)? ……
…..Do you suffer from headaches / migraines?
…..Do you have any visual disturbances (fuzzy, double or tunnel vision, etc.) ……..
…..Do you suffer from dizziness / vertigo / weakness?
…..Are you prone to fainting or epileptic fits?
…..Do you have a sensation of 'pins and needles' or numbness in your hands or feet?
…..Are your emotions fairly stable?
…..Are you prone to sudden mood changes?
…..Are you an anxious person?
….Is your long term memory bad?
….Is you short term memory bad?
.....Is your concentration bad?

Emotional Profile

….Do you have panic attacks?
….Do you have particular fears or phobias (spiders, illness, losing a job, etc.)?
....Are you a shy person?
….Do you feel like your mind is over-strained and you are going to explode or do irrational things?
….Are you overly anxious about other people including your loved ones and worry about bad thngs happening to them?
….Are you very critical of others and find them difficult to accept them as they are? (a bit intolerant)
….Do you spend a lot of time and energy trying to convert people to your way of thinking?
….Do you wash your hands obsessively? Do you find something 'unclean' about yourself?
….Are you prone to circular or repetitive thinking when it's hard to switch off (cluttered head)?
…..Are you impatient and often want things done faster? Or frustrated with other people being slow?
….Are you a high achiever, often overwork and ignore your tiredness?
….Do you feel overwhelmed by work or life situations to the point of being depressed and exhausted?
….Have you suffered a misfortune that you find difficult to accept and feel sulky, grumpy and sorry for yourself?
….Are you easily discouraged and disheartened?
….Do you have bouts of sudden gloom or depression for no apparent reason ('dark cloud')?
.....Are you a jealous person?
….Are you calm or cheerful on the outside but troubled inside? (successfully hiding your feelings)
….Are you tormented by fear that something bad is going to happen but can't say what exactly? (vague fear)
….Are you a 'push-over' and easily neglect your own needs for those of others?
….Do you lack confidence to make your own decisions and need advice and approval of others?
….Do you tend to make the same mistakes over and over again?
....Are you a day-dreamer, living more in the future than in the present?
….Do you tend to be quite possessive with those people you care about?
….Do you dislike being alone and always need company of others?
….Do you pine after the 'good old days' and live in the past?
….Do you feel that whatever you do you are unlikely to succeed and give up easily?
....Is daily life a hard work for you without any pleasure? (feeling physically or mentally exhausted)
….Do you tend to blame yourself for anything that goes wrong?
….Do you prefer to be alone and go about your own business?

Glucose Tolerance Profile

….. Awaken a few hours after falling asleep, hard to get back to sleep?
….. Do you need more than 8 hours sleep a night?
….. Are you rarely wide awake within 20 minutes of rising?
….. Do you need something to get you going in the morning, like a tea, coffee or cigarette?
….. Do you have tea, coffee, sugary foods or drinks, or cigarettes at regular intervals during the day?
…...Do you crave sweets, desserts or sugary snacks?
….. Are you prone to binges or uncontrolled eating bouts?
…...Do you need to urinate frequently?
……Do you get drowsy after a meal?
….. Do you often feel drowsy during the day?
….. Do you get dizzy, shaky or irritable if you miss a meal?
….. Do you avoid exercise due to tiredness?
….. Do you sweat a lot or get excessively thirsty?
….. Do you sometimes lose concentration?
Rate your energy level on the scale 0 – 10 (10 being the highest): ……

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Digestion Profile

….. You have a good appetite?
……Do you tend to over-eat?
……Do you chew your food thoroughly?
……Do you have any dental problems? ……
……Do you tend to eat 'on the go'?
……Do you have difficulty swallowing your food?
….. Do you sometimes suffer from bad breath?
….. Are you prone to stomach upsets?
….. Do you often get a burning sensation in your stomach?
….. Do you find it difficult digesting fatty foods?
….. Do you occasionally use indigestion tablets?
….. Do you suffer from flatulence or bloating?
….. Do you experience anal irritation?
….. Do you have a bowel movement daily? How many times a day……..
…..Is it formed?
…..Do you strain passing a stool?
What colour is it usually? Please underline: milk chocolate, dark brown, tarry almost black, whitish, greenish, yellow, orange
…..Do you ever get light or clay coloured stools?
….. Do your stools float?
…..Do you ever suffer from abdominal pain? Describe in which area …….
…..Do you ever get the feeling that food is just sitting there like a heavy brick?
…. Have you ever experienced rectal bleeding? What colour was the blood (bright red or dark)? …….
…..Do you have haemorrhoids?
…..Do you feel nauseous or vomit easily?
…..Do you get belching or gas within 1 hour of a meal?
…..Do you get abdominal bloating 1-2 hours after eating?
…..Are you a vegan (no dairy, meat, fish or eggs)?
…..Do you suffer from chronic diarrhoea?
…..Do you feel like skipping breakfast?
…..Do you have anaemia unresponsive to iron?
…..Do you get pain between shoulder blades?
…..Do you have headaches over the eye?
…..Do you have white spots on fingernails? How many? ……
…..Do your nails have vertical ridges and split easily?
…..Do you get bitter taste in the mouth, especially after meals?
…..Do you get easily intoxicated by alcohol or become sick if drinking wine?
…..Do you have any history of drug or alcohol abuse?
…..Are you sensitive to chemicals (perfume, solvents, exhaust, insecticides)?
…. Do you use artificial sweeteners (e.g. aspartame)? ……..
…..Have you ever suffered from chronic fatigue or fibromyaligia?
…..Do you suffer from Crohn's disease or mucous colitis? (underline)

Allergy Profile

Please tick if you suffer from any of the following:
_ Asthma. _ Eczema. _ Dermatitis. _ Migraine. _ Irritable bowel. _ Frequent bloating. _ Facial puffiness. _ Sinus congestion
_ Feeling spacey or unreal. _ Dark circles under eyes. _Fungal infections.

Do you have any allergies? If so, to what? (drugs, foods, environmental factors)
……
State type of reaction: ……
Have they been tested? (where and when):……

Immune Profile

….. Do you get more than three colds a year?
….. Do you find it hard to shift an infection (cold)?
….. Do you have frequent infections (ear, sinus, lungs, skin, bladder, kidney, etc.)
….. Do you have a runny or drippy nose?
….. Do you have fevers frequently?
…..Were you breast fed as a child?
…..Were you delivered by a Caesarean?
….. Are you prone to thrush or cystitis?
….. Do you often take antibiotics more than twice a year?

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….. Is there a history of cancer in your family?
….. Have you ever had any growths or lumps biopsied?
….. Do you have an inflammatory disease such as eczema, asthma or arthritis?
….. Do you suffer from hay fever?
….. Do you suffer from allergy problems?
…..Have you had a major personal loss in the last year?
…..Do you have a history of Epstein Barr, Mono, herpes, shingles, chronic fatigue, hepatitis or other chronic viral condition?
…..Do you suffer from any auto-immune conditions? (rheumatoid arthritis, lupus, Crohn's, ankylosing spondilitis, Hashimoto's thyroiditis, etc.) …….
…..Is your immune system compromised in any way? (HIV, immuno-supressant medication, chronic viral infection, etc.)

Urinary System Profile

….. How often do you urinate? (times s day)…….
…...Is there any urgency?
……How much urine do you pass each time (a copious or scanty amount?)
……Have you ever noticed blood in your urine or smoky appearance of urine?
……Is there any pain on urination?
……Is there any loin pain?
……Do you suffer from incontinence?
Please underline the description of urine: straw colour, almost transparent, fluorescent yellow, smoky, cloudy, concentrated darkened yellow, odourless, slight urine odour, strong unpleasant odour
……Do you have any pain in mid back region or on the flanks?
……Do you have dark circles under eyes and/or puffy eyes?
……Have you ever had kidney stones?
……Have you ever had a kidney infection?
……Have you ever had an STD? ……
……

Additional Questions for Women Only

……When did you first start menstruating? (age) …….
….. Are you pregnant? If so how many weeks?: …….
….. Are you trying to become pregnant?
….. Have you ever had a miscarriage?
……Have you ever had a pregnancy terminated?
….. Do you have an IUD fitted, or use the birth control pill?
Please state which: ……
….. Are your periods regular?
…..How many days is your cycle length? ……..
…..Are there any variations in menstrual cycles?
…..Do you skip an occasional cycle?
…..How long does the bleeding last? …….
…..Do you have period pain? (please underline): slight, medium, strong, debilitating
…..Are your periods very light, medium or heavy? (underline)
…..Do you have clots in the menstrual blood?
…..What colour is the blood (underline): bright red, watery, dark red, brownish
…..Have you ever been diagnosed with endometriosis?
…..Do you have ovarian cysts?
…..Do you have uterine fibroids?
…..Do you experience pain during intercourse?
…..Do you have any vaginal discharge? (colour, odour) ……

Please tick if you suffer from any pre-menstrual symptoms:
_ Bloating. _ Tiredness. _ Irritability. _ Depression. _ Headaches. _ Breast tenderness. _Mood swings.

….. Are you post-menopausal?
Please tick if you experience any menopausal symptoms:
_ Hot flushes. _Night sweats. _Headaches. _Irritability. _Depression. _Vaginal dryness. _Lack of libido. _Tinnitus.

Additional Questions for Men Only

….. Do you have any prostate problems?
….. Do you wake regularly at night to urinate?
….. Do you find it difficult to start & stop the urine stream?

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….. Do you notice any dribbling during the course of the day?
…...Do you have any pain on the inside of your legs or heels?
…...Do you have a feeling of incomplete bowel evacuation after passing stools?
…...Have you noticed any decrease in libido or sexual function?

Musculo-Skeletal Profile

……Do you have any joint pain? (indicate which joints)……
……Do you experience joint stiffness?
……What makes it better? ……
……What makes it worse? ……
……Do you have any joint swelling?
……What back problems do you have? ……..……..
……Do you have any neck problems? ……
……Have you ever had any injuries (broken bones, torn ligaments, etc.)? ……..
……Have you ever had a surgery on your spine, neck, knees, hips, etc.? ……..
……Do you suffer from muscle spasms/ cramps?
……Calf, foot or toe cramps at rest
……Restless legs at night
……Bone lass (reduced bone density revealed on bone scan)
……History of stress fractures
……Fibromyalgia
……Bursitis or tendonitis
……Herniated disk
……Joints pop or click
……Osteoarthritis diagnosed
……Rheumatoid arthritis diagnosed
……Bone spurs

Endocrine Profile

……Difficulty gaining weight, even with large appetite
……Nervous, emotional, can't work under pressure
……Allergic to iodine
……Inward trembling
……Flush easily
……Hot person (before menopause); can't tolerate heat
……Loose stools
……Prefer to drink cold drinks
……Fast pulse at rest
…....Heart palpitations (rapid heartbeat)
……Difficulty losing weight
……Sensitive to cold; cold hands and feet
……Chronic constipation
……Loss of outer 1/3 eyebrow
……Excessive hair loss and/ or coarse hair
……Deepened voice
……Mentally sluggish, reduced initiative
……Easily tired, sleepy during the day
……Morning headaches that wear off during the day
……Describe your energy levels throughout the day ……..
……Enlarged front of the neck (goitre)
……Excess body hair

Skin Profile

……Acne
……Dry, flaky skin
……Oily, greasy skin
……Eczema or dermatitis
……Hives or rashes
……Psoriasis
……Fungal infections (athlete's foot, jock itch, nail fungus, ring worm)
……Herpes
……Vitiligo (loss of skin pigmentation, white patches)
……Birth marks, moles or raised dark patches

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DIGESTIVE ANALYSIS/ EATING HABITS

_____ Alcohol
_____ Artificial sweeteners
_____ Chocolate, sweets
_____ Carbonated beverages
_____ Cigarettes, pipes, cigars
_____ Tea (non herbal)
_____ Sugar
_____ Canned food
_____ Eat fast /instant food regularly
_____ Fried foods
_____ Luncheon meats/ hot dogs
_____ Margarine
_____ Milk products
_____ Add salt to food or cooking
_____Diet often
_____ White rice or products made from white wheat flour (bread, pastry, pasta)
_____ Vitamins and minerals
_____ Water, filtered or bottled
_____ Water, tap
_____ Eat on the move or when stressed

…….. Was a significant proportion of your diet as a child high in sweet or fatty foods?
……..Do you go out of your way to avoid foods containing additives or preservatives?
…….. Do you try to avoid foods containing sugar?
…….. What % of your diet is raw fruit or veg. (inc. salad)? ……
What is your usual alcoholic drink? ……..
…….. How many units do you drink each week? ……..
…….. Does your job involve eating out a lot?
How would you describe your appetite? 1 = poor 2 = average 3 = good (circle)
…….. Do you or can you cook for yourself?
…….. Do you enjoy cooking?
…….. Do you mainly purchase organic produce?
…….. Have you recently changed your diet?
…….. Do you steam vegetables rather than boil?
…….. How many coffees do you drink each day?
…….. How many cups of tea do you drink each day?
…….. Do you mainly drink decaffeinated coffee or herbal tea?
…….. How many teaspoons of sugar do you add to food or drinks each day?
…….. How many pints of milk do you drink each week?
…….. How many times a week do you have meals containing fried food?
…….. How many times a week do you eat ”junk” food?
…….. How many times a week do you eat “ready” meals?
…….. How many times a week do you eat chocolate or confectionary?
…….. How many cans of food do you eat each week?
…….. How many slices of bread or rolls do you eat each week?
…….. How many times a week do you eat red meat (beef, pork, lamb; incl. ham, sausages, burgers)?
…….. How many times a week do you eat white meat or fish?
…….. How many times a week do you eat oily fish (salmon, mackerel, pilchards, whitebait, fresh tuna, herring, etc.)?
…….. How many glasses of water do you drink each day?
…….. How many portions of fruit / veg. do you eat each day?

FOOD PREFERENCES

List any foods you avoid for religious / cultural / ethical / health reasons: ……

.....

List any foods that you suspect “don’t agree with you”: ……

List any foods you would find hard to give up: ……

.....

List any foods you crave:

……

.....

List any foods you dislike: ……

…….

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Terms of Business

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Please read the paragraphs below then sign both copies of this sheet. Keep one copy for yourself and bring the other along to your initial consultation.

1. The Naturopathic Health Assessment Questionnaire and food diary sent to you should be returned to Health Revisited to arrive at least 48 hours prior to the initial consultation. Failure to return them in time may result in the consultation being postponed.
2. You may cancel any appointment but please try to give at least 48 hours notice. If you cancel with less than 24 hours notice you may be charged 50% of the full consultation fee.
3. Consultation fees are **£95 for the initial consultation (1 hr)** and **£75 for a 45 minutes' follow-up**. The fee for each consultation is payable either by cash or cheque at the end of the consultation – please remember to bring your cheque book with you.
4. The suitability of the naturopathic and nutritional advice and guidance you are given depends to a large extent on the accuracy with which you complete the questionnaire and food diary (although clarifications may made during the consultation). No responsibility can be accepted if important information is withheld. In particular, you should give full details of diagnosed medical conditions and any medications being taken, details of any changes in diagnoses and/or medication which occur whilst you are following your nutritional programme and full details of any nutritional supplements, homeopathic or herbal preparations you are taking.
5. The benefit achievable from herbal remedies and nutritional therapy varies between individuals with similar health concerns and following similar therapy programmes. No claim is made as to the efficacy of any protocol as it will depend on how well your body responds to it.
6. The results you obtain from your herbal and nutritional therapy programme will also depend upon your degree of compliance with the advice provided. No responsibility can be accepted in cases of non-compliance.
7. It is your responsibility to inform your doctor of the herbal or nutritional programme you are following and you are advised to do so even if you are not being treated by him/her. This is to avoid any undesirable interactions between medication and the naturopathic programme.
8. To avoid adverse reactions it is important that you do not continue your naturopathic programme beyond the agreed time period.
9. You will be fully involved in the decision making process regarding the options to be included in your naturopathic programme. Either during or after your initial consultation you will be sent details of the programme, including dietary and lifestyle recommendations, a nutritional supplement programme and herbal preparation made specifically for you.
10. Your naturopathic programme may, with your agreement, include biochemical tests which can be done through your GP or privately.
11. If you are at all unclear about the naturopathic programme (including, but not limited to, nutritional supplement dosages, time periods, etc) you should contact your Naturopath promptly for clarification.
12. Do not be tempted to modify the programme on the advice of a third party, without the consent of your Naturopath.
13. Naturopaths, Nutritional therapists and Herbalists are not permitted to diagnose or claim to treat any medical condition. Their advice is not a substitute for professional medical treatment. The aim of natural medicine is to facilitate the body's own re-balancing and self-healing in an attempt to alleviate undesirable health conditions. You are responsible for contacting your doctor with regard to any medical health concerns you may have.
14. Data Protection: The information you provide on the Naturopathic Health Assessment Questionnaire and that gathered during consultations is recorded in writing by Health Revisited and may be transferred to computer. It includes personal data relating to your health and brief details of your family unit. Health Revisited will process and hold this data for future reference. Other (non-medical) personal information may be used for the purposes of administration only. We can confirm that we take careful measures to keep all such information secure. Our policy is not to disclose it to any third party without your written consent. Returning this form duly signed constitutes your express consent to the processing of this data.

I understand the above and agree that our professional relationship will be based on the content of this document.

Signed by the client: ..... Date: .....

Signed by the therapist: ..... Date: .....

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12. Do not be tempted to modify the programme on the advice of a third party, without the consent of your Naturopath.
13. Naturopaths, Nutritional therapists and Herbalists are not permitted to diagnose or claim to treat any medical condition. Their advice is not a substitute for professional medical treatment. The aim of natural medicine is to facilitate the body's own re-balancing and self-healing in an attempt to alleviate undesirable health conditions. You are responsible for contacting your doctor with regard to any medical health concerns you may have.
14. Data Protection: The information you provide on the Naturopathic Health Assessment Questionnaire and that gathered during consultations is recorded in writing by Health Revisited and may be transferred to computer. It includes personal data relating to your health and brief details of your family unit. Health Revisited will process and hold this data for future reference. Other (non-medical) personal information may be used for the purposes of administration only. We can confirm that we take careful measures to keep all such information secure. Our policy is not to disclose it to any third party without your written consent. Returning this form duly signed constitutes your express consent to the processing of this data.

I understand the above and agree that our professional relationship will be based on the content of this document.

Signed by the client: ..... Date: .....

Signed by the therapist: ..... Date: .....

Marina Townsley **07551 327899**
Naturopath ND, Nutritional Therapist, Master Herbalist
healthrevisited@aol.com