

Family medical history

Please indicate medical conditions suffered by family members

Father.....
.....
Mother.....
.....
Siblings.....
.....
Other (grandparents, aunts, uncles)
.....
.....

Signs and symptoms

Circulatory system

Have you been diagnosed with the following, please give details.

Raised blood pressure.....
Raised cholesterol.....
Raised blood sugar.....
Heart problems
Anaemia.....
Stroke (including TIA).....

Do you smoke? Yes/no. If yes, how much.....

Do you get any regular exercise, please specify.....
.....

Do you suffer from..(please tick)

Pain in legs on walking	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	Swollen ankles	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>

Immune system

Have you been diagnosed with any of the following?

Asthma.....
Hayfever.....
Eczema.....
Rheumatoid Arthritis or other autoimmune disease.....
.....

Do you have any allergies or intolerances to foods or anything in your environment, please specify.....
.....

Number of colds, viral infections per year.....

Please tick any of the following that apply to you....

Blocked/runny nose	<input type="checkbox"/>	Itchy throat	<input type="checkbox"/>
Post nasal drip	<input type="checkbox"/>	Fluctuating energy	<input type="checkbox"/>
Unexplained rash	<input type="checkbox"/>	Headaches	<input type="checkbox"/>
Thrush infections	<input type="checkbox"/>	Urine infections	<input type="checkbox"/>
Joint pains	<input type="checkbox"/>	Bloating	<input type="checkbox"/>

Hormonal and nervous system

Have you been diagnosed with a glandular disorder, including thyroid problems, please specify.....

Have you been diagnosed with any neurological disorder, such as epilepsy, stroke, MS, Parkinson's disease.....

Have you suffered from any mental health problems such as anxiety, depression, schizophrenia, bi-polar disorder? Please give details.....

What are the major stressors in your life?.....

What do you do to relax?.....

Please tick any of the following which apply to you.

- | | | | |
|-----------------------------|--------------------------|------------------------|--------------------------|
| Excessive thirst | <input type="checkbox"/> | Fatigue | <input type="checkbox"/> |
| Excessive urination | <input type="checkbox"/> | Dry hair/skin | <input type="checkbox"/> |
| Blurred vision | <input type="checkbox"/> | Feel the cold | <input type="checkbox"/> |
| Mood swings | <input type="checkbox"/> | Difficulty getting up. | <input type="checkbox"/> |
| Need to eat frequently | <input type="checkbox"/> | Insomnia | <input type="checkbox"/> |
| Low mood | <input type="checkbox"/> | Hyperactive | <input type="checkbox"/> |
| Difficulty relaxing | <input type="checkbox"/> | Irritability | <input type="checkbox"/> |
| Poor memory | <input type="checkbox"/> | Excess stress | <input type="checkbox"/> |
| Difficulty getting to sleep | <input type="checkbox"/> | Nighttime waking | <input type="checkbox"/> |

Women only

Age at which periods started.....

Are your periods regular?.....

Do you have painful and/or heavy periods?.....

Do you use any hormonal contraception or HRT? Please specify.....

Are you pregnant or planning a pregnancy?.....

Have you had difficulty conceiving?.....

Have you experienced a miscarriage?.....

Have you experienced gynaecological problems such as endometriosis, polycystic ovaries, ovarian cysts?.....

Have you experienced any breast problems such as mastitis, or lumps in the breast?.....

Do you check your breasts regularly?.....

Digestive Health

Have you been diagnosed with any digestive disorder such as heartburn, inflammatory bowel disease, gall bladder problems etc? Please specify.

.....
.....
.....

Please tick any of the following which apply to you.

- | | | | |
|-------------------------|--------------------------|-------------------------|--------------------------|
| Change in bowel habit | <input type="checkbox"/> | Frequent antibiotic use | <input type="checkbox"/> |
| Constipation | <input type="checkbox"/> | Abdominal pain | <input type="checkbox"/> |
| Diarhorrea | <input type="checkbox"/> | Flatulence | <input type="checkbox"/> |
| Frequent bowel motions | <input type="checkbox"/> | Smelly stools | <input type="checkbox"/> |
| Pain on opening bowels | <input type="checkbox"/> | Irritable bowel | <input type="checkbox"/> |
| Blood in stool | <input type="checkbox"/> | Weight loss | <input type="checkbox"/> |
| Bloating | <input type="checkbox"/> | Eat when stressed | <input type="checkbox"/> |
| Discomfort after eating | <input type="checkbox"/> | Poor alcohol tolerance | <input type="checkbox"/> |
| Kept awake by caffeine | <input type="checkbox"/> | Intolerance to fat | <input type="checkbox"/> |

Weight history

Height.....

Current weight.....

Ideal weight.....

Are you happy with your weight?.....

Difficulty gaining weight

Abdominal weight gain

Difficulty losing weight

Weight gain on hips

Diet History.

Do you follow a special diet such as vegetarian, vegan, gluten free?.....

.....

Do you have any food allergies or intolerances? Please specify.....

.....

Are there any foods you dislike?.....

.....

Are there any foods you crave?.....

.....

Number of cups of coffee per day.....

Number of cups of tea per day.....

Pints of beer per week.....

Glasses of wine per week.....

Glasses of spirits per week.....

Is there anything else that you feel would be helpful for the therapist to know?

Please give typical dietary intakes for one weekday and one weekend day below, listing all food and drink consumed.

Weekday
On rising.....
.....
Breakfast.....
.....
.....
time eaten.....
Lunch.....
.....
.....
time eaten.....
Evening meals.....
.....
.....
time eaten.....
Snacks and drinks (state times).....
.....
.....
.....

Weekend day
On rising.....
.....
Breakfast.....
.....
.....
time eaten.....
Lunch.....
.....
.....
time eaten.....
Evening meals.....
.....
.....
time eaten.....
Snacks and drinks (state times).....
.....
.....
.....

Signed.....

Date.....