# 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 naturaltherapy4me@gmail.com
If you do not have e-mail then please call 6477047578 to ask where it should be posted.

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**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 getting nutritional treatment? (Y/N)
Do you give your authorization for your GP to be contacted? (Y/N)
GP's Name: ..... Address:
.....
..... Post Code:
.....
What is your main reason for getting nutritional advice?
.....
List the outstanding health concerns you have in the order of importance and specify how long you have had them
(Use a separate sheet if necessary):
Health Problem Duration
1.

2.

3.
4.
5.

Under what conditions do these problems get worse?

Under what situations do they get well?

Can you suggest the origin of any current illness to any specific
incident? (e.g. accident, illness, grief, mental upset etc.)

ANY SEVERE SHOCK, GRIEF, DISAPPPOINTMENT, FEAR, DEPRESSION, ETC.?

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List any major surgery or important periods of illness in your life and any chronic or minor health problems:

Give details (date, reason) of any antibiotic use in the past 1 year?

**Have you ever suffered from any of the next disease?**
**Please circle or ( ) any that apply:**

Anemia, Asthma ,Abscesses, Arthritis, Cancer, Chicken Pox, Cold Sores, Diabetes, Eczema, Emphysema, Epilepsy, Frequent Colds, Gallstones, Genital Herpes, Gonorrhea, Gout, Heart Disease, Hepatitis, HIV, Influenza, Kidney Disease, Leukemia, Lyme disease, Malaria, Measles, Mononucleosis, Mumps, Parasites, Pelvic Inflammatory Disease, Peritonitis, Pleurisy, Pneumonia, Prostatitis, Psoriasis, Rheumatic Fever, Rubella, Skin Diseases, Scarlet Fever, Sinusitis, Sexual Abuse, Strep Throat, Stroke, Sunstroke, Syphilis, Tonsillitis, Tuberculosis, Typhoid Fever, Whooping Cough, Venereal Warts, Warts , Worms, Yellow Fever
Other:

## PERSONALITY PROFILE

Many times your health can be affected by your mental/emotional condition. As an assistance to aid determine the best homeopathic remedy for you, please circle or ( ) any of the following characteristics that describe you best.

Energetic- Playful -Sociable -Convincing –Inspirational- Spirited –Follower- Unplanned Hopeful -Humorous –Charming- Happy- Motivating- Friendly -Mixes easily –Communicator- Dynamic -Cut Popular- Bouncy- Brassy -Unmanageable -Boring -Forgetful -Interrupts – Unpredictable- Haphazard -Permissive -Angered easily- Naïve -Wants credit –Talkative- Disorganized Inconsistent -Show-off- Loud –Scatter brained -Restless -Changeable – Adventurous- Persuasive Strong-willed- Competitive- Resourceful -Self-reliant -Positive -Sure – Outspoken- Forceful Daring- Confident- Independent- Decisive- Mover –Tenacious- Leader - Chief –Productive- Bold Bossy -Unsympathetic -Resistant –Frank- Impatient- Unaffectionate – Headstrong- Proud Argumentative -Anxious Workaholic-Thoughtless- Bossy- Intolerant- Manipulative -Stubborn Short-tempered -Rash -Crafty- Logical -Determined -Self-sacrificing - Understanding -Respectful Sensitive Planner-Planned –Organised- Truthful -Comprehensive - Cultivated -Idealistic -Deep- Musical Thoughtful –Loyal –Caretaker- Perfectionist- Behaved- Timid -Unforgiving –Annoyed- Fussy Insecure -Unpopular -Hard to please- Pessimistic - Alienated -Negative attitude -Withdrawn Too sensitive -Depressed -Introvert -Moody -Skeptical - Loner- Suspicious- Revengeful- Critical Adaptable -Peaceful –Submissive- Controlled - Reserved –Pleased- Patient- Helpful- Friendly Diplomatic -Consistent -Inoffensive -Dry humour- Mediator- Easy going –Listener- Satisfied Permissive- Sensible- Unqualified -Unenthusiastic - Unwilling –Fearful- Hesitant- Uninvolved Hesitant Plain -Lost -Calm –Neurotic –Shy- Unsure - Uncaring –stutters- Slow –Lazy- Hesitant- Cooperating

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Please circle or ( ) any of the following medications you are currently taking or have taken in the last month:

Antacids - Anticonvulsants - Antibiotics - 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 other recommended medications you are presently taking (name and dose):

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

Your weight: Height. Blood Pressure: Pulse Rate:

**Please scan and attach /or take along 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 susceptible to?

If you have any children what illnesses are they vulnerable to?

Do/did your parents or grandparents suffer from any disease (e.g. heart disease, diabetes, asthma etc)? Provide 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 currently aware of.

**Life Style Analysis**

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

**Cardiovascular Profile**

Is your blood pressure beyond 140/90?
Is your pulse after 20 minutes' rest above 75?
Are you more than 16lbs (7kg) over your ideal weight?
Do you smoke more than 6 cigarettes a day?
Do you do less than 2.30 hours exercise a week?
Do you consume more than one spoonful of sugar a day?
Do you eat red meat more than 4 times a week?
Do you usually add salt to your food?
Do you have more than 1 alcoholic drinks a day?
Is there a history of heart illness in your family?
Do you experience boring pain or tightness in the chest?

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Do you have any chest pain that spreads into the left arm?
Do you get short of breath easily after light physical exertion?
Air hunger" or yawn frequently?
Do you have a constant night cough?
Are you aware of heart palpitations (fast 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 physical movements that noticeably raises your heart rate for 20 minutes more than 3 times a week?
Does your job involve dynamic activity?
Do you regularly play a sport?
Do you have any physically exhausting hobbies (gardening, cycling etc)?
How many times a week and how long do you work out, 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 3 hours a week in traffic?
Do you exercise (cycle,etc) by busy roads?
Do you smoke? How many cigarettes a day?
Do you live or work in a smoke-filled atmosphere?
Do you buy foods exposed to exhaust smokes?
Do you generally eat non-organic produce?
Do you drink more than 1 unit(10ml )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 uncertain about your aims in life?
Are you especially competitive?
Do you work harder than most people?
Do you work more than 46 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?

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Do you often do 2 or 3 tasks at once?
Do you get irritated if people or things hold you up?
Do you have difficulty getting to sleep?
Do you gain weight mainly around your abdomen?
Do you crave salty foods?
Do you feel wired or nervous 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)?
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 specific 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, irritable and sorry for yourself?
Are you easily discouraged and disheartened?
Do you have sessions of sudden sadness 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 suffering by fear that something bad is going to occur but can't say what exactly? (Vague fear)
Are you a 'push-over' and easily neglect your own desires for those of others?
Do you lack confidence to make your own choices and need recommendation and approval of others?
Do you tend to make the similar mistakes over and over again?
Are you a day-dreamer, living more in the future than in the present?

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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 happiness? (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):

**Digestive 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, and 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?

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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 vegetarian (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, and insecticides)?
Do you use artificial sweeteners (e.g. aspartame)?
Have you ever suffered from chronic fatigue or fibromyalgia?
Do you suffer from Crohn's disease or mucous colitis? (Underline)

**Allergy Profile**

Allergies & Sensitivities
Please list all allergies & sensitivities
Include drugs, foods, and chemicals environmental

Please indicate if you suffer from any of the following: **Please circle or ( ) any that apply:**

_ 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 get better an infection (flu)?
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?
Is there a history of cancer in your family?
Have you ever had any growths or lumps biopsied?
Do you have an inflammatory disease for example eczema, asthma or arthritis?
Do you suffer from hay fever?
Do you suffer from allergy problems?
Have you had a major individual loss in the last year?

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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 spondylitis, Hashimoto's thyroiditis, etc.)

Is your immune system compromised in any way? (HIV, immuno-suppressant 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**

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Do you have any prostate problems?
Do you need to get up often at night to urinate?
Do you have difficulty starting or stopping the urine stream?
Do you have any dribbling during the course of the day?
Do you have any ache on the inside of your legs or heels?
Do you have a sensation of inadequate bowel evacuation after passing stools?
Have you noticed any decline 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

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**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

**DIGESTIVE ANALYSIS/EATING HABIT. Please circle or ( ) any that apply:**

Alcohol- Artificial sweeteners- Chocolate, sweets- Carbonated beverage- 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 consume steamed vegetables rather than boiled?
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?

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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?

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:
.....
.....

## REPORTING SYMPTOMS –

Determining the proper homeopathic remedy involves investigating and evaluating all the subjective and objective symptoms that you are experiencing in the context of your physical symptoms, individual life circumstances and environment. In order to develop an accurate picture of your circumstances, and to make our time spent in consultation most effective, I request that you think about and keep in mind the following requests for information, as in-depth and accurately as possible. If you have any questions, feel free to contact us.

1. Think about, in detail, the onset of your symptoms. Any related mental, emotional or physical symptoms and/or any external condition(s) that may have contributed to your state of being at that time?

2. Think about all previous illnesses. Include any childhood diseases and if applicable, any lasting effects from these aliments. Were there any extensive therapies employed in the healing of these conditions? Did you have any reactions or long-term side effects to any such therapies?

3. Think about the symptom you are experiencing in terms of location in the body. Does this symptom shift from one place in your body to another? Related symptoms elsewhere in the body? Particular sensations associated with the symptom? How it feels/looks/smells/tastes? Anything that makes the symptom unique, striking or unusual? If pain is involved, think about the pain you endure ex. a dull ache vs. a sharp stabbing pain, a constant or periodic pain etc. Think about the onset of your pain; slow vs. sudden? How intense is the pain?

4. Make note of when your symptoms feel better or worse: time of day/ when you are hot or cold/hot or cold compresses/months/seasons/before or after eating/ sleep/moving resting certain positions/when occupied/ specific mental/emotional states. Experiment with heat or cold, warm rooms or fresh cool air, warm or cool bathing. Do you notice any difference in the symptom?

*5.* Are you affected in any way by different kinds of weather? Dryness/ humidity/ approaching storms/ thunderstorms/ frost/ cloudiness/ low or high altitudes/ being by the seashore.

6. Urination (if of concern): Colour/ odour/ sediment/ quantity/ frequency/ urgency.

7. Stool (if of concern): Number of stools per day/ colour/ odour/ hard/ dry/ large/ pasty/ bloody/ frothy/ slimy/ thin/ watery/ slender/ flat/ difficult or incomplete/ urging without stool.

8. Menses: Length of cycle/ length of period/ significant pain associated with menses/ length of period/ nature of the flow/ clotting cramping PMS/ mood swings/ bloating swollen tender breasts/ Cravings/ vaginal discharge with or without menses.

9. Sex: Desires/aversion/ painful intercourse/ vaginal dryness/ impotency.

10. Perspiration: Profuse/ scanty/ odour.

11. Body Temperature: Hot vs. cold body type/ hot or cold hands or feet/ hot flashes.

12. Sleep: Do you wake up at night? When? Why? How do you feel in the morning on rising? What position do you sleep-side/back/front? Are parts of the body covered or exposed with sleep? Do you have recurring dreams in your sleep? Are there any prominent themes to your dreams? Night terrors?

13. What motivates you in life? Are there lasting traits from childhood that are still an issue today? Are there running themes in your life? eg. “All my life I’ve been...”. How would others describe you? How do you deal with change in your life? Do you need structure in your life?