

Health Questionnaire

Name		Date of Birth	
Today's date		How did you hear of this service?	
Email address		Home address	
Contact Phone number		Male or female	
Please put cross in relevant box	Yes No		Yes No
Are you or could you be pregnant?	<input type="checkbox"/> <input type="checkbox"/>	Do you have any skin conditions?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever had any diseases other than normal childhood diseases?	<input type="checkbox"/> <input type="checkbox"/>	Do you regularly get headaches or migraines?	<input type="checkbox"/> <input type="checkbox"/>
Do you have any allergies that you know of?	<input type="checkbox"/> <input type="checkbox"/>	Do you smoke?	<input type="checkbox"/> <input type="checkbox"/>
Do you consider yourself as being stressed?	<input type="checkbox"/> <input type="checkbox"/>	Are your energy levels low?	<input type="checkbox"/> <input type="checkbox"/>
Are you diabetic?	<input type="checkbox"/> <input type="checkbox"/>	Do you suffer joint pain?	<input type="checkbox"/> <input type="checkbox"/>
Have you had any surgery?	<input type="checkbox"/> <input type="checkbox"/>	Do you suffer fungal infections?	<input type="checkbox"/> <input type="checkbox"/>
Do you need surgery?	<input type="checkbox"/> <input type="checkbox"/>	Do you regularly suffer from bladder problems?	<input type="checkbox"/> <input type="checkbox"/>
Do you suffer from depression?	<input type="checkbox"/> <input type="checkbox"/>	Do you have problems with your bowels??	<input type="checkbox"/> <input type="checkbox"/>
Do you suffer from hay fever?	<input type="checkbox"/> <input type="checkbox"/>	Do you get wind or bloating?	<input type="checkbox"/> <input type="checkbox"/>
If you have answered yes to any questions please give as much detail here about what is happening, use overleaf if you need to.			
What are the main symptoms you are looking for help with today? Give details of health concerns i.e.: wind /bloating, skin rash etc		Are you currently following a special diet? if so what?	
What medication are you taking?		What supplements are you taking?	
Any other details you think are important.		This information is treated with the strictest confidence.	
Cost of analysis	Initial consultation including full analysis £100	Follow up consultation after 6 weeks of following the recommended advice £50	Pay for both initial consultation and follow up together at a reduced cost of £135
		I understand this information to be true	Signed.