

Health Questionnaire Follow up form

Your Name	Todays date		
Please put cross in relevant box.	Yes	No	
Have you followed the advice given on the initial analysis report?	<input type="checkbox"/>	<input type="checkbox"/>	What dietary changes have you made?
Have you found it fairly easy to follow?	<input type="checkbox"/>	<input type="checkbox"/>	Thinking about the main reasons you wanted help in the first place, how much better do you feel? 0 = No better, 10 = fully improved.
Are you taking any new medication/supplements?	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what new medication/supplement?
If you have any new symptoms please describe what.			
This information is treated with the strictest of confidence.		I understand this information to be true.	Signed.....