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?	☐	☐	**What dietary changes have you made?**	
Have you found it fairly easy to follow?	☐	☐	**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?	☐	☐	**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…..