tim rees

DIET & LIFESTYLE COACHING

Health & Lifestyle Questionnaire (HLQ)

(STRICTLY CONFIDENTIAL)

Nutritionist	Tim		
Skype Address: or similar	tim-rees		
Mobile:	+49 151 55 77 16 09	**Email:**	tim@tim-rees.com
Consultation date/time	tbc by email		

How to use this form - helpful reminders:

- Please complete all sections of the forms as accurately as you can **on your computer.**
- Please note **ONE symptom/ condition only in each Condition box** and please make sure that **you specify the symptom / condition to be addressed clearly** (e.g. digestive problems is not a symptom or a condition, whereas bloating is).
- This form will **automatically 'tick'** any questions previously answered if used with a suitable PDF viewer/editor.
- If any answers on the HLQ are incorrect, your nutrition programme may be inappropriate and I / we will not take responsibility for any consequences as the result of inaccurate information
- **Please keep a copy of your electronic questionnaire on your computer or print a hard copy, so you can have it with you during your consultation.**
- Please note that some questions on the HLQ are repeated in several sections. Each consecutive section will be automatically ✓ once you have answered the question for the first time.
- Please ignore section 21, which is for Office Use only.
- **Please email your completed HLQ with any other relevant documents to tim@nutritionaltherapyonline.com**

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DIET & LIFESTYLE COACHING

STRICTLY CONFIDENTIAL

Please consider all questions carefully and answer as accurately as you can

First Name:		**Surname:**		**Gender:**	
Address:					
Postcode:		**Country of Domicile:**			
Tel No (home):		**Tel No (Work):**			
Tel No (Mobile):		**E-Mail / web address:**			
Date of Birth:	**Age:**	**Height:**	**Weight:**	**BMI** (office use):	
How many children / dependents do you have?		**Job / Occupation:**			

YOUR MAIN HEALTH CONCERNS

Condition No 1	**Please list any known triggers**	**Duration & how managed** (e.g. diet, exercise, medication, etc.)

Office Use Only:	
Tests:	

Condition No 2	**Please list any known triggers**	**Duration & how managed** (e.g. diet, exercise, medication, etc.)

Office Use Only:	
Tests:	

Condition No 3	**Please list any known triggers**	**Duration & how managed** (e.g. diet, exercise, medication, etc.)

Office Use Only:	
Tests:	

CURRENT MEDICAL HISTORY - please note any other health issues not mentioned above (e.g. allergies, infections, etc.)**:-**

Office Use Only:	

PAST MEDICAL HISTORY - **please provide details of any serious illnesses & / or operations you have had in the past** (e.g. mumps, glandular fever, etc.). **Please provide dates whenever possible** (e.g. January 2005):-

Office Use Only:	

TIMELINE OF HEALTH CONCERNS:
Please provide a timeline for your health concerns (according to your age when they began). **Please include any key events such as: periods of stress, food poisoning, illness, toxin exposure, etc.** Add any triggers you have noticed for your conditions and start with the earliest age first (examples in red italics).

Age	**Health concerns**	**Additional info** (e.g. medications, stressful episode, etc.)
e.g. 3 - 5	*e.g. Multiple ear infections*	*e.g. Many antibiotics*

Office Use Only:	

Have you had any RECENT MEDICAL or FUNCTIONAL TESTS (within last 12 months)? Please provide details / results and attach copies if available.

Office Use Only:	

MEDICATIONS - if you take any medications briefly note why, name & dosage, prescribed by whom & duration:-

Office Use Only:	

SUPPLEMENTS - if you take any supplements please note name, brand & dosage, prescribed by whom & why:-	
Office Use Only:	
FAMILY HISTORY - please note any illnesses / conditions in your blood relatives (e.g. heart dx, cancer)**:-**	
Office Use Only:	
OTHER THERAPIES - if you are seeing any other practitioners (e.g. a homeopath, a herbalist) **please state why:-**	
Office Use Only:	
Red Flags (please highlight any that apply to you):	
Pain	any pain which is persistent or severe: ☐ in the abdomen ☐ back ☐ chest ☐ eye ☐ head ☐ neck ☐ temple ☐ on passing urine ☐ **any other** (please list below):-
Bleeding	☐ blood in sputum ☐ vomit ☐ urine or stool ☐ postmenopausal bleeding ☐ rectal bleeding ☐ **any other** (please list below):-

Changes in	☐ appetite ☐ bowel habit ☐ passing of urine ☐ personality/behavior ☐ body or face shape ☐ vision ☐ skin ☐ moles ☐ breathing ☐ swallowing ☐ **any other** (please list below):-
Any other	☐ amenorrhea ☐ black tarry stools ☐ breast lumps ☐ calf swelling ☐ crushing chest pain ☐ excessive thirst ☐ increased urination ☐ erectile dysfunction ☐ loss of appetite ☐ night sweats ☐ nipple discharge ☐ tired all the time ☐ palpitations ☐ persistent cough ☐ pins & needles ☐ recurrent mouth ulcers ☐ tingling sensation ☐ unexplained bruises ☐ unexplained joint pain ☐ unexplained skin rash ☐ unexplained weight loss ☐ vaginal discharge ☐ **any other** (please list below):-
Office Use Only:	
Tests:	
Additional Information **Please note any other additional information that may be relevant to your health below:-**	
Office Use Only:	
Tests:	

YOUR DIET ANALYSIS

Please consider all questions carefully and answer as accurately as you can

On average:-

How often do you eat **white bread, pasta, rice, pastry,** etc.?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **biscuits or cakes**?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **chocolate or sweets**?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **crisps or chips**?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **salads**?	rarely		2-3 / week		3-4 / week		daily					
How many portions of **vegetables** do you eat each day?	none		2-3 / day		3-4 / day		Other					
How many portions of **fresh fruit** do you eat each day?	none		2-3 / day		3-4 / day		Other					
How often do you eat **dairy products** (e.g. milk, butter, etc.)?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **red meat** (e.g. beef, pork, lamb)?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **processed meat** (e.g. ham, sausages, bacon)	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **poultry** (e.g. chicken, duck, goose)?	rarely		2-3 / week		3-4 / week		daily					
How many portions of **oily fish** (salmon, mackerel, sardines, fresh tuna, trout, anchovies) do you eat each week?	none		1-2 / week		3-4 / week		Other					
How often do you eat **nuts and seeds**?	rarely		2-3 / week		3-4 / week		most days					
How many cups of caffeinated **coffee** do you drink each day?	none		1-2 / day		3-4 / day		Other					
How many cups of decaffeinated **coffee** do you drink each day?	none		1-2 / day		3-4 / day		Other					
How many cups of **black / white / green** tea do you drink each day?	none		1-2 / day		3-4 / day		Other					
Do you **add milk and sugar** to tea or coffee?	both		milk only		sugar only		none					
How many **alcoholic drinks** do you drink each day?	none		1-2 / day		3-4 / day		Other					
What is your usual alcoholic drink?	wine		beer		spirits		Other					
How many cups of **herb** or **fruit tea** do you drink each day?	none		1-2 / day		3-4 / day		Other					
How many **carbonated drinks** you have each day (e.g. cola)?	none		1-2 / day		3-4 / day		Other					
How many **fruit juices** you drink each day (e.g. orange juice)?	none		1-2 / day		3-4 / day		Other					
How many glasses of **water** do you drink each day?	none		1-2 / day		3-4 / day		Other					
How often do you eat **ready-made meals?**	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **deep fried** foods?	rarely		2-3 / week		3-4 / week		daily					
How often do you eat **barbecued or chargrilled foods?**	rarely		2-3 / week		3-4 / week		daily					
How often do you add **salt** to food at the table?	never		occasionally				always					

What are your typical cooking methods?

Deep-frying		Stir-frying		Pan-frying		Grilling	
Boiling		Steaming		Braising		Roasting	
Baking		Poaching		Microwaving		Ready-made	

Other - e.g. a take-away

Which oils do you use for cooking?

Olive oil		Peanut oil		Corn oil		Other:	
Sunflower oil		Rice bran oil		Grape seed oil			
Avocado oil		Sesame oil		Coconut oil			

Which oils do you use on salads?

Virgin olive oil		Hemp / canola oil	
Walnut oil		Sunflower oil	
Flax / linseed oil		**Other:**	

Please note below any dietary restrictions that you may follow for cultural or health reasons (e.g. vegetarian, vegan, avoid pork, etc.):-

Do you find that a particular food disagrees with you? If YES, please note below which, and the symptoms you experience:-

Would you find any specific foods difficult to give up? If YES, please state which, below:-

If you have a history of eating disorders or disordered eating (e.g. anorexia, bulimia, comfort eating, binge eating, etc.), briefly explain below:-

DIGESTION

Please consider all questions carefully & answer as accurately as you can

1. HCl

You have a diagnosed gastric ulcer		You often **feel nauseous after eating a meal**	
You have been diagnosed with gastritis		You often **experience belching after eating a meal**	
You often experience an acid taste in the mouth		You often **experience indigestion after eating a meal**	
You experience burning pain if you swallow hot drinks		You often **experience bloating after eating a meal**	
You have a diagnosed **history of H. Pylori infection**		You often **experience flatulence after a meal**	
You **avoid salt and salty foods**		You often suffer from **constipation**	
You **do NOT chew food thoroughly**		You have **less than 1 bowel movement daily**	
You **often eat in a hurry**		Your **stools are often difficult to pass**	
You have **weak, peeling or split nails**		You are **prone to foul smelling stools**	
You often **find undigested food in the stools**		You **often experience diarrhoea**	
You **find it difficult to digest meat**		You **often get alternating constipation & diarrhoea**	
Your **stomach feels heavy for hours after eating**		You **often experience rectal itching**	
You often **feel nauseous after taking supplements**		You **frequently suffer from a yeast / candida infection**	

Office Use Only:	
Tests:	

2. GB

You have a family history of **gall bladder disease**		Your **stools tend to be light tan / clay coloured**	
You have had your **gallbladder removed**		You **often get loose, foul smelling stools**	
You have been diagnosed with **gallstones**		You experience **intolerance to greasy foods**	
You have been diagnosed with a **gallbladder disease**		You experience **indigestion after eating fatty foods**	
You often experience **yellowing of the skin** (jaundice)		**Get pain radiating to the back & the right shoulder**	
You tend to get **yellow in the whites of the eyes**		You often get **pain in the centre of your abdomen**	

Office Use Only:	
Tests:	

DIGESTION

Please consider all questions carefully and answer as accurately as you can

3. IP

You are **undergoing radiation therapy**		You suffer from **multiple food allergies / sensitivities**	
You are **undergoing chemotherapy**		You often **experience bloating, gas or cramps**	
You have a diagnosed **autoimmune disease**		You often get **alternating constipation & diarrhoea**	
You've been diagnosed with **ulcerative colitis or Crohn's dis.**		You often get **mucus in the stools**	
You have been diagnosed with **food allergies or sensitivities**		You suffer from **eczema or dermatitis**	
You have been diagnosed with **coeliac** disease		You are **prone to skin eruptions** (e.g. acne, hives)	
You have a **history of taking antibiotics**		You suffer from **asthma**	
You have **taken antibiotics in the last 5 months**		You **frequently get sinusitis**	
You **regularly take NSAIDs** (e.g. ibuprofen or aspirin)		You often experience **unexplained muscle pain**	
You have a **stressful lifestyle**		You often experience **unexplained joint pain**	
You drink **more than 3 alcoholic drinks daily**		You find it **difficult to gain weight**	
You are prone to **chemical sensitivities** (e.g. perfumes)		You **regularly feel unwell** (flu-like symptoms)	
You suffer from **gluten intolerance**		You experience **chronic or frequent tiredness**	

Office Use Only:	
Tests:	

4. DYSB

You have been diagnosed with a **parasitic infection**		You often **experience lack of concentration**	
You have had a **parasitic infection in the past**		Eating **fruit makes you feel bloated**	
You have **travelled to a 3rd world country**		You often suffer from **constipation**	
You have **lived in a 3rd world country**		You often **experience abdominal bloating & gas**	
You have a **history of taking antibiotics**		You often get **alternating constipation & diarrhoea**	
You have a **stressful lifestyle**		You often **get loose, foul-smelling stools**	
You frequently **suffer from yeast infections**		You often **find mucus in your stools**	
You are **prone to fungal skin or nail infections**		You **often get diarrhoea**	
You often **crave bread or starchy and sugary foods**		You often **experience rectal itching**	

Office Use Only:	
Tests:	

LIVER & ELIMINATION

Please consider all questions carefully and answer as accurately as you can

5. LIVER

You have a family history of **liver disease**		You have **taken medications for weeks, months or years**	
You have a history of **gallstones**		You experience **chronic or frequent tiredness**	
You have a history of **alcohol abuse**		You are **prone to headaches**	
You have a history of **drug addiction**		You **often feel nauseous**	
You've been diagnosed with a **liver disease**		You often suffer from **bad breath**	
You have been diagnosed with **elevated liver enzymes**		You tend to suffer from **body odour**	
You have been diagnosed with **hepatitis**		You often suffer from **vomiting**	
You are **considerably overweight**		You suffer from a **swollen abdomen** (tummy)	
You have had a **liver transplant**		You experience **easy bruising**	
You normally **drink more than 3 alcoholic drinks daily**		You are prone to **skin eruptions** (e.g. hives)	
You **suffer from alcohol addiction**		You suffer from **chronic itching**	
You **regularly use recreational drugs**		You get **yellow in the whites of the eyes**	

Please note below any other issues related to your liver, not listed in the above profile, below:-

Office Use Only:	
Tests:	

6. ELIMINATION

You've been diagnosed with a **liver disease**		You **suffer from a kidney disease**	
You have a family history of **liver disease**		You **suffer from a lung disease**	
You have a history of **gallbladder disease**		You often suffer from **constipation**	
You exercise **less than 3 x per week?**		You have **less than 1 bowel movement per day**	
You **drink less than 2 liters of fluids per day**		You are **prone to skin eruptions**	
You **suffer from fluid retention**		You **do NOT perspire / sweat easily**	

Please note below any other information that you feel may be relevant:-

Office Use Only:	
Tests:	

GT & CV HEALTH

Please consider all questions carefully and answer as accurately as you can

7. BSI

You **cannot go for more than 3 hours without a meal / snack**		You **often eat desserts or sugary foods**	
If a meal is missed you get **irritable or moody**		You often **crave caffeinated drinks** (e.g. cola, coffee, tea)	
If a meal is missed you **find it hard to concentrate**		You often **crave cigarettes**	
If a meal is missed you **feel weak or dizzy**		You **do NOT have protein with each meal** (e.g. meat, fish, nuts)	
If a meal is missed you **feel anxious**		You experience **excessive appetite**	
If a meal is missed you experience **fast pulse or palpitations**		You often **feel drowsy in the afternoon**	
If a meal is missed you experience **trembling or shakiness**		**Eating relieves fatigue**	

Office Use Only:	
Tests:	

8. IR, MetS & T2D

You have a family history of **type 2 diabetes**		You **find it difficult to lose weight**	
You have been diagnosed with **pre-diabetes**		You are a diagnosed **diabetic**	
You have been diagnosed with **PCOS**		Your **breath smells sweet**	
You have been diagnosed with **high blood pressure**		You have recently experienced **unexplained weight loss**	
You have been diagnosed with **abnormal cholesterol levels**		You often experience **chronic & frequent tiredness**	
You tend to lead a **sedentary lifestyle**		You often experience **excessive thirst**	
You are **considerably overweight**		You often experience **excessive urination**	
You suffer from **central obesity** (fat around the middle)		You tend to experience **slow healing of wounds or cuts**	

Office Use Only:	
Tests:	

9. CVD Profile

You have a family history of **heart disease**		You are a regular **smoker**	
You have a family history of **stroke**		You **drink more than 3 alcoholic drinks daily**	
You have a family history of **type 2 diabetes**		You have a **stressful lifestyle**	
You are a diagnosed **diabetic**		You **eat less than 5 portions of fruit & veg a day**	
You have been diagnosed with **cardiovascular disease**		You eat **oily fish** less than twice per week	
You have had a **stroke/s**		You eat **deep-fried foods more than 3 x** per week	
You have been diagnosed with an **underactive thyroid**		You **eat red meat more than 3 x per week**	
You have been diagnosed with **high blood pressure**		You often get **palpitations** (rapid heartbeat)	
You have been diagnosed with **abnormal cholesterol** levels		You often experience **weakness and dizziness**	
You are **considerably overweight**		You get **easily out of breath** (not asthma)	
You suffer from **central obesity** (fat around the middle)		You often experience **pounding in your chest**	
You tend to lead a **sedentary lifestyle**		You often experience **chest pain on exertion**	
You **exercise less than 3 x per week**		You often **feel dizzy & light-headed**	

Office Use Only:	
Tests:	

EMOTIONAL & PSYCHOLOGICAL HEALTH

Please consider all questions carefully and answer as accurately as you can

10. EMOTIONAL & MENTAL HEALTH

You have a family history of **mental health issues**		You tend to **binge eat / comfort eat**	
You have a family history of **depression**		You suffer from **mood swings**	
You have a history of **alcohol addiction**		You easily **get irritable or 'short-fused'**	
You have a history of **drug addiction**		You experience **uncontrollable anger**	
You have been diagnosed with **mental health issues**		You experience **uncontrollable physical aggression**	
You have been diagnosed with **depression**		You often feel **absent-minded or forgetful**	
You have been diagnosed with **bipolar disorder**		You often feel **overwhelmed**	
You have been diagnosed with **schizophrenia**		**Everything seems like a chore**	
You have been diagnosed with **personality disorder**		You find **less enjoyment or happiness in life**	
You have been diagnosed with **OCD**		You **require increased effort to do everyday tasks**	
You have been diagnosed with an **eating disorder**		You do **not feel emotionally supported**	
You suffer from undiagnosed **depression**		You **find it hard to make time for yourself**	
You have a **stressful lifestyle**		You suffer from **panic attacks**	
You are currently **dealing with stressful family issues**		You feel **isolated / lonely**	
You **do not use any stress reduction methods** (e.g. yoga)		You are **worried about your health**	
Your **sleep is NOT restful**		You have **financial worries**	
You **drink more than 3 alcoholic drinks daily**		You **have a history of being psychologically abused**	
You suffer from **alcohol addiction**		You **have a history of physical abuse**	
You regularly **use recreational drugs**		You are **experiencing problems at work**	

Please note below any other emotional issues not listed in the above profile:-

Office Use Only:	
Tests:	

11. NT IMBALANCES

Office Use Only:	
Tests:	

ADRENAL & THYROID FUNCTION

Please consider all questions carefully and answer as accurately as you can

12. Cortisol Profile

You have been diagnosed with **Cushing's syndrome**		You **regularly take NSAIDs** (ibuprofen or aspirin)	
You have a **stressful lifestyle**		You often **crave caffeinated drinks** (e.g. cola, coffee, tea)	
You tend to **work long hours**		You **crave salt or salty foods**	
You often **find it hard to relax**		You find it **difficult to handle stress**	
You often **find it difficult to fall asleep**		You **easily get irritable or 'short-fused'**	
You often **wake up at night and cannot get back to sleep**		You often **feel absent-minded or forgetful**	
You find it **difficult to build muscle**		You often feel **overwhelmed**	
You suffer from **central obesity** (fat around the middle)		You **find less enjoyment or happiness in life**	
You often experience **unexplained anxiety**		You often experience **chronic or frequent tiredness**	
You suffer from undiagnosed **depression**		You still feel **tired after a good night's sleep**	
You are **prone to allergies & sensitivities**		You are suffering from **reduced productivity**	
You have been diagnosed with **Addison's disease**		**Exercise causes fatigue**	
You have been diagnosed with **low blood pressure**		You **feel light-headed when standing up quickly**	
You have been diagnosed with an **underactive thyroid**		You experience **frequent inflammation**	

Office Use Only:	
Tests:	

13. TH Profile

Your **periods are irregular**		You experience **cold hands & feet**	
You suffer from **heavy menstrual flow**		You have a **puffy-looking face**	
You have a **history of miscarriages**		Your **eyebrows are thinned or partly missing**	
You have a family history of **thyroid disease**		You experience **excessive hair loss**	
You have been diagnosed with an **underactive thyroid**		Your **skin is dry and scaly**	
You have been diagnosed with **coeliac** disease		You **bruise easily**	
You have a diagnosed **autoimmune disease**		You experience **muscle aches and weakness**	
You have been diagnosed with **abnormal cholesterol levels**		You often get **muscle cramps**	
You find it **difficult to lose weight**		You suffer from **slow / sluggish digestion**	
You experience **reduced libido / less interest in sex**		You often suffer from **constipation**	
You have **problems with fertility**		You have been diagnosed with an **overactive thyroid**	
You experience **chronic & frequent tiredness**		You **often feel hyperactive**	
You suffer from **slow thinking & movements**		You **find it difficult to gain weight**	
You suffer from **undiagnosed depression**		You experience **unexplained weight loss**	
You have a **slow heart rate (pulse)**		You **suffer from mood swings**	
You tend to suffer from **anaemia**		You are **sensitive to / dislike heat**	

Office Use Only:	
Tests:	

FEMALE & MALE HEALTH

Please consider all questions carefully and answer as accurately as you can

14. FEMALE Health only

You are trying to get pregnant		You have an **IUD fitted**	
You have **problems with fertility**		You **suffer from PMS**	
You are undergoing IVF treatment		You often **experience period pains (cramps)**	
You have a **history of miscarriages**		Your **periods are irregular**	
You are pregnant or lactating (breastfeeding)		You suffer from a **heavy menstrual flow**	
You have a family history of **breast cancer**		You suffer from a **prolonged menstrual flow**	
You have a family history of **uterine fibroids**		You experience **spotting or bleeding between periods**	
You have a family history of **endometriosis**		You often get **thrush**	
You have a family history of **PCOS**		You suffer from **frequent urinary tract infections**	
You have a family history of **osteoporosis**		You experience **reduced libido / less interest in sex**	
You have been diagnosed with **breast cancer**		**You have had a hysterectomy**	
You have been diagnosed with **fibrocystic breast disease**		You are **peri-menopausal** (approaching menopause)	
You have been diagnosed with **uterine fibroid/s**		You are **menopausal**	
You have been diagnosed with **endometriosis**		You are **taking HRT**	
You have been diagnosed with **PCOS**		You suffer from **'menopausal' depression/ mood swings**	
You have been diagnosed with **osteopenia or osteoporosis**		You suffer from **'menopausal' insomnia**	
You have been diagnosed with **HPV infection**		You suffer from **vaginal dryness**	
You have been diagnosed with **ovarian cysts**		You suffer from **hot flushes & night sweats**	
You are **receiving treatment for a STD**		Your **skin is dry & thinning**	
You are taking a **contraceptive pill / have an implant**		You are **post-menopausal**	

Please note any other health issues not listed in the above profile, below:-

Office Use Only:	
Tests:	

15. MALE Health only

You have been diagnosed with **BPH** (benign prostatic hyperplasia)		You experience **reduced libido / less interest in sex**	
You have been diagnosed with **prostatitis**		**You are over 50**	
You have been diagnosed with **testicular disease**		You suffer from **erectile dysfunction**	
You have been diagnosed with **low testosterone levels**		You find it **hard to pass urine**	
You have been diagnosed with a **low sperm count**		You experience **pain when passing urine**	
You have been diagnosed with **prostate cancer**		You experience **burning when passing urine**	
You have been diagnosed with **male breast cancer**		You experience **frequent or excessive urination**	
You've been diagnosed with a **sexually transmitted disease**		You frequently **wake up at night to urinate**	
You have been diagnosed with **osteopenia or osteoporosis**		You experience **difficulty in starting to urinate**	
You are experiencing **problems with fertility**		You tend to experience **a weak urine flow**	

Please note any other health issues not listed in the above profile, below:-

Office Use Only:	
Tests:	

POLLUTION PROFILE

Please consider all questions carefully and answer as accurately as you can

16. ENVIRONMENT

You **rarely buy organic foods**		You have **recently decorated / renovated your home**	
You believe **organic food is not any healthier**		You **usually cycle on busy roads**	
You **do NOT wash fruit and vegetables before eating**		You live/lived in a **mouldy/damp** or LG floor home	
You normally **drink tap / unfiltered water**		You **live or work near a busy road**	
You have **amalgam (silver) fillings**		You **live or work in a city**	
You had **amalgam fillings removed recently**		You **live or work near an industrial plant**	
You **do NOT use natural personal care products**		Your job involves **working with chemicals**	

Office Use Only:

17. SMOKING (if you are not a smoker or a passive smoker, please proceed to the next section)

You are a regular **smoker**		You **do NOT wish to stop smoking**	
You are a **passive smoker**		You've **tried to stop smoking in the past**	
You are a **social smoker** (e.g. weekends only)		You've been **advised to stop smoking by your GP**	

If advised to stop smoking, briefly explain why, below:-

What do you normally smoke?	**cigarettes**		**E-cigarettes**		**cigars**		**pipe**	
How many cigarettes do you smoke a day?	**1 - 10**		**10 - 20**		**20 - 30**		**30 - 60**	
At what age did you start smoking?	**teens**		**20's**		**30's**		**later**	

If you are using any other sources of tobacco, please list below (e.g. shisha):-

If you have any smoking-related health issues please explain which, below:-

Office Use Only:

18. Recreational Drugs (if you do not use any recreational drugs please proceed to the next section)

You regularly **use recreational drugs**			You have a **history of drug addiction**					
How often do you use recreational drugs?	rarely		monthly		weekly		**daily**	
Which recreational drugs do you use?	**cannabis**		**heroin**		**cocaine**		**other**	
At what age did you start to take drugs?	**teens**		**20's**		**30's**		**later**	

If you have any drug-related health issues please explain which, below:-

Office Use Only:

Tests:

IMMUNITY & ALLERGIES

Please consider all questions carefully and answer as accurately as you can

19. IMMUNITY Profile

You have a family history of **cancer**		You are **receiving treatment for HIV (STD)**	
You have had **growths or lumps biopsied**		You have a **stressful lifestyle**	
You are undergoing **radiation therapy**		You suffer from **lack of sleep**	
You are undergoing **chemotherapy**		You do not exercise regularly / have a **sedentary lifestyle**	
You have diagnosed **CFS / ME**		You catch **more than 3 colds a year**	
You have a diagnosed **autoimmune disease**		You get **more than 3 infections a year**	
You have a diagnosed **bacterial infection**		Your **lymph glands are frequently swollen or sore**	
You have a diagnosed **viral infection**		You find it **hard to shift colds or infections**	
You have a diagnosed liver disease		You are **off sick more than 3 times per year**	
You have a history of **frequent bacterial infections**		You **take longer to recover from an illness or injury**	
You have a history of **frequent viral infections**		You are **prone to cold sores**	
You are prone to **dental infections**		You are **prone to mouth ulcers**	
You have been **hospitalised in the last 6 months**		You are **prone to yeast infections**	
You have a history of **taking antibiotics**		You suffer from **frequent urinary tract infections**	
You **regularly take NSAIDs** (ibuprofen or aspirin)?		You are **prone to various allergies / sensitivities**	

Please note below any other immune issues not listed in the above profile:-

Office Use Only:	
Tests:	

20. ALLERGY & INTOL Profile

You have **undergone allergy testing**		Your **weight tends to fluctuate**	
You have been diagnosed with **food allergies or sensitivities**		You often experience **unexplained joint pain**	
You have been diagnosed with **lactose intolerance**		You often experience **unexplained muscle pains**	
You have been diagnosed with **fructose intolerance**		You often **get itchy or watery eyes** (not hayfever)	
You have been diagnosed with **histamine intolerance**		You have a **constant runny nose**	
You have been diagnosed with **coeliac disease**		You **frequently get sinusitis**	
You suffer from **gluten intolerance**		You suffer from **excessive mucus production**	
You **crave / binge on particular foods or drinks**		You have a **constant sore throat**	
You experience **gas / bloating after eating certain foods**		You are **prone to skin eruptions** (e.g. acne)	
You get **diarrhoea after eating certain foods**		You are prone to **itchy skin** (pruritus)	
You get **abdominal cramps after eating certain foods**		You are prone to **chemical sensitivities** (e.g. perfumes)	
You suffer from **fluid retention after eating certain foods**		You suffer from **hay fever**	
You feel **fatigued / drowsy after eating certain foods**		You suffer from **asthma**	
You **experience facial puffiness after eating certain foods**		You suffer from **eczema or dermatitis**	
You **experience facial flushing after eating certain foods**		You often suffer from **urticaria** (hives)	

Please note below any known allergies not listed above, or any foods that disagree with you:-

Office Use Only:	
Tests:	

21. INFLAMMATION

OFFICE USE ONLY - this section will be completed automatically!

Diet & Lifestyle		Allergy Profile	
You **drink more than 3 alcohol drinks daily**		You have been diagnosed with **food allergies or sensitivities**	
You suffer from **alcohol addiction**		You are **prone to allergies & sensitivities**	
You are a regular **smoker**		You are prone to **chemical sensitivities** (e.g. perfumes)	
You regularly **use recreational drugs**		You suffer from **eczema or dermatitis**	
You eat **less than 5 portions of fruit & veg a day**		You are prone to **skin eruptions** (e.g. hives)?	
You eat **oily fish less than twice per week**		You often suffer from **urticaria** (hives)	
You eat **deep-fried foods more than 3 x per week**		You suffer from **hay fever**	
You **eat red meat more than 3 x per week**		You suffer from **asthma**	
		You frequently get **sinusitis**	
Digestive Profiles		You often experience **unexplained muscle pain**	
You've been diagnosed with **ulcerative colitis or Crohn's dx**		You often experience **unexplained joint pain**	
You suffer from **gluten intolerance**			
You have a diagnosed **history of H. Pylori infection**		**Female Health**	
		You have been diagnosed with **breast cancer**	
MetS & CVD Profile		You have been diagnosed with **PCOS**	
You are a diagnosed **diabetic**		You have been diagnosed with **fibrocystic breast disease**	
You have been diagnosed with **cardiovascular disease**		You have been diagnosed with **uterine fibroid/s**	
You have been diagnosed with **high blood pressure**		You have been diagnosed with **endometriosis**	
You are **considerably overweight**		You have been diagnosed with **ovarian cysts**	
You **suffer from central obesity** (fat around the middle)		You often **experience period pains (cramps)**	
Adrenal Profile		**Male Health**	
You **regularly take NSAIDs** (e.g. iboprufen or aspirin)		You have been diagnosed with **prostate cancer**	
You have a **stressful lifestyle**		You have been diagnosed with **male breast cancer**	
You find it **difficult to handle stress**		You have been diagnosed with **prostatitis**	
You experience **frequent inflammation**		You have been diagnosed with **BPH**	
		You find it **hard to pass urine**	
Immunity		You experience **pain when passing urine**	
You are **undergoing radiation therapy**		You experience **burning when passing urine**	
You are **undergoing chemotherapy**		You experience **frequent or excessive urination**	
You are receiving **treatment for a STD or HIV**		You experience **difficulty in starting to urinate**	
You have a diagnosed **autoimmune disease**		You have a **weak urine flow**	
You have a diagnosed **bacterial infection**			
You have a diagnosed **viral infection**		**Miscl**	
You catch **more than 3 colds a year**		You have been diagnosed with **osteopenia or osteoporosis**	
You catch **more than 3 infections a year**		You have a **diagnosed liver disease**	
You are prone to **dental infections**		You are a **regular smoker**	
You suffer from **frequent urinary tract infections**			

Office Use Only:	
Tests:	

Miscellaneous Information

Confidentiality

- All your information and records are confidential and no disclosure will be made to a third party (including members of your family), without your written consent, except where it is required by due process of law, whether that be by statute, statutory instrument, order of any court or competent jurisdiction.
- No third party, including assistants and members of your family, may be present during the course of the consultation without your consent.
- Under the Freedom of Information Act (HMSO 2000) you have the right to access your own records.

Data Protection Statement

- I comply with the Data Protection Act 1998. At no time will your personal information be passed to organisations for marketing or sales purposes.

Your Responsibilities as a Client

- You are responsible for contacting your GP/Medical Doctor with any health concerns
- If you are not being treated by your GP/MD, you may still let him / her know that you are receiving nutritional therapy.
- If you are receiving treatment from your GP, or any other medical provider, you should tell them about any nutritional strategy provided by me. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that you tell me about any medical diagnosis, prescribed medications, modifications, herbal medicine, or food supplements you are taking, as this may affect the nutritional programme.
- If you are unclear about the agreed nutritional therapy programme / food supplement doses / time period, you should contact me promptly for clarification.
- You must contact me should you wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions.
- You are advised to contact me promptly about any concerns about the recommended Nutritional Therapy programme for discussion and further action/s.

Please note your GP/MD's details below (we will NOT contact them without your written permission):-

Declaration:

I hereby confirm that this information is correct to the best of my knowledge and that I am not withholding any important information.

Date: _____ **Signed:** _____