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Name _____ Date of Birth _____

Medical History
Do you have any medical problems / major illnesses? Please list these with dates of diagnoses.

Regular Medications
Please list all current prescribed medications and supplements.

Allergies
Do you have any known allergies to medications? If yes, please list and describe the reaction.

Do you have any other allergies? eg dustmite /moulds Please list.

Do you have any food intolerances?

Family History
(Please tick if any of these have occurred in your family and state which relative)

	Heart Disease	
	Stroke	
	Diabetes	
	Cancer	
	Bowel Cancer	
	Breast Cancer	
	Ovarian Cancer	
	Melanoma	
	Autoimmune Disease eg. Lupus, Rheumatoid Arthritis, Coeliac Disease, Hashimoto's /Graves Disease, Psoriasis	

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ADULT QUESTIONNAIRE

Circle the appropriate score 1 = Very poor 2 = Poor 3 = Neutral/Fair 4 = Good 5= Very good

GUT HEALTH

Do you suffer from significant burping, reflux, heartburn, bloating or abdominal pains?	YES NO UNSURE
If you suffer from bloating, how soon after eating?	30-60 mins 1-3 hours > 3 hours
Do you have a regular well formed bowel habit?	YES NO UNSURE
If not do you have a tendency to constipation ☐ diarrhoea ☐ both ☐	
Do you ever see undigested food particles in your stool?	YES NO UNSURE
Do you feel you digest you food well?	YES NO UNSURE
Please list any other problematic digestive symptoms	

MENTAL HEALTH

How is your memory?	1 2 3 4 5
How is your concentration?	1 2 3 4 5
Has there been a recent deterioration in either of these?	YES NO
How is your motivation?	1 2 3 4 5
Over the last 2 months how would you rate your mood?	1 2 3 4 5
Do you consider yourself to be a pessimist or an optimist?	
Do you suffer from anxiety or panic attacks?	YES NO UNSURE
Have you suffered from depression or melancholia in the past?	YES NO UNSURE
Are you overly sensitive to noise?	YES NO
Do you have a short fuse? Or suffer from anger, rage or severe frustration?	YES NO

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MUSCULOSKELETAL /SKIN HEALTH

Do you suffer from significant headaches, migraines or muscular pains?	YES NO
Do you suffer from any recurring skin conditions? Eczema, rash, acne, dry skin, other _____	YES NO UNSURE
Do you suffer from muscular cramps?	YES NO
Does cheap jewellery (e.g. nickel) give you a rash or discolour your skin?	YES NO UNSURE

SLEEP

Do you remember your dreams? How often: nightly, weekly, monthly other _____	YES NO
Do you dream in full colour, pastels or black and white?	
Overall, how do you feel you sleep?	1 2 3 4 5
Do you have problems getting to sleep?	YES NO UNSURE
What is you average time from when you put your head on the pillow to when you fall asleep?	_____ mins/hours
Do you have problems staying asleep? If so when are you waking and what is waking you? Bladder, thoughts, discomfort in body, other _____	YES NO UNSURE
Are you a light sleeper? Are you easily woken or often aware of noises?	YES NO UNSURE
Are you an active sleeper? (Frequent movements, restless legs)	YES NO UNSURE
Do you have any "night behaviours," such as teeth grinding, sleep walking/talking, night terrors, "calling out"?	YES NO
Do you feel refreshed when you wake in the morning?	YES NO
If you are waking tired do you often feel "Zombie Like"?	YES NO

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ENERGY

Do you suffer from lethargy or fatigue?	YES	NO	UNSURE
Over the last 2 months how would you rate your overall energy?	1 2 3 4 5		
Are there times during the day when your energy typically takes a dip? Midmorning, early afternoon, early evening?	YES	NO	UNSURE
Do you suffer from fatigue or severe muscle ache after activity?	YES	NO	UNSURE
If you have fatigue do you often find you are better in the evening?	YES	NO	UNSURE
Do you have food cravings? What for?	YES	NO	UNSURE
Are you sensitive to bright lights?	YES	NO	UNSURE
Do you sometimes experience mild dizziness on standing?	YES	NO	UNSURE

EXERCISE

What exercise and physical activity do you regularly do?		
How often do you exercise per week?	Times per week	
Do you do more than 150 minutes exercise per week?	YES	NO
What exercise have you done in the past that you have enjoyed?		
What forms of exercise and physical activity are accessible/ avaiable to you in the near future?		

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CHILDHOOD HISTORY

Were you a full term or near full term baby?	YES	NO	UNSURE
Did your mother have a lot of emotional or physical stress during your pregnancy?	YES	NO	UNSURE
Were you breast fed? For how long?. _____months	YES	NO	UNSURE
Did you have eczema as a baby?	YES	NO	UNSURE
Were you told that as a baby you had "colic", feeding problems, recurrent regurgitation?	YES	NO	UNSURE
Did you have any major childhood illness/hospitalizations? Please List	YES	NO	UNSURE
Did you have any recurring tonsillitis, ear infections, asthma, hay fever, bronchitis?			
Did you have recurring anxiety and/or worry as a child?	YES	NO	UNSURE
Did you experience significant trauma as a child (physical or emotional)?	YES	NO	UNSURE
Did you have lots of energy as a child? i.e. played lots of sport	YES	NO	UNSURE
As a teenager did you suffer from depression, anxiety, eating disorders or moderate to severe acne?	YES	NO	UNSURE

TOXIN EXPOSURE

Do you have amalgams?	YES	NO	UNSURE
Have you worked in any jobs known to contain toxic materials? E.g. Renovations/ warehouses/ plumbing/ electrician/ beautician/ hairdressing (exposure to pesticides/ petrochemicals) Please List	YES	NO	UNSURE
Do you/ have you had any hobbies that may have caused significant exposure to toxins? E.g. welding/lead light windowing/surfboard repairs Please List	YES	NO	UNSURE

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SMOKING HISTORY

Current Smoker ☐ Non – Smoker ☐ Ex – Smoker ☐

If a smoker / ex smoker, number smoked per day _____

Year commenced _____ Year quit _____

ALCOHOL INTAKE

Never ☐ Less than monthly ☐ 1-2 days per month ☐ 1-2 days per week ☐
3 – 4 days per week ☐ 5 – 6 days per week ☐ Every day ☐

Average number of drinks per day _____

BRIEF DIETARY HISTORY

Do you eat:
Red meat ☐ Chicken ☐ Fish ☐ Dairy ☐ Wheat ☐
Are you intolerant of any foods / or foods you do not eat? (please list)

Completion of 7 Day Menu Plan ☐

If you could change anything about your wellbeing today how would that look/feel to you?

We would like to send you health updates via email.
Please indicate here if you DO NOT want to hear from us ☐

Signature Date