Health Appraisal Questionnaire

Please take the time to answer all questions as honestly and accurately as possible. The more information you're able to provide, the better we can tailor your treatment plan. All details will be held in the strictest confidence. Please bring this form completed with you to your consultation

Name: Date:

Circle or highlight the number which best describes the frequency of your symptoms.

0 = never or rarely (leave blank)
1 = twice a week or less
2 = three to six times a week
3 = frequently eg daily or several times a day

Digestive System

Do you suffer from….

Indigestion or heartburn	1	2	3
Excessive belching or burping	1	2	3
Premature sense of fullness after only a small amount of food	1	2	3
Poor appetite, disinterest in food	1	2	3
Bad breath or taste in mouth	1	2	3
History of anaemia or iron deficiency	1	2	3
Sores in corner or mouth	1	2	3
Regular bloating (not related to period)	1	2	3
Excessive or foul smelling flatulence	1	2	3
Nausea or feeling queasy	1	2	3
Constipation, difficult bowel movements or less than one a day	1	2	3
Roughage and fibre cause constipation	1	2	3
Regularly use laxatives	1	2	3
Diarrhoea (loose / urgency / frequency more than 3 a day)	1	2	3
Alternating constipation or diarrhoea	1	2	3
Abdominal cramps or spasm	1	2	3
Stool contain undigested food or mucus	1	2	3
Digestive problems subside with rest and relaxation	1	2	3
History of parasite infection	1	2	3
Known or suspected food allergies or intolerances	1	2	3
Vegetarian or vegan (no eggs or dairy)	1	2	3

Nervous system

Do you ….

Feel stressed, nervous or tense	1	2	3
Feel irritable or overly sensitive	1	2	3
Experience difficulty concentrating	1	2	3
Have coffee, tea, cigarettes, sweets or some other stimulant as a pick-me-up	1	2	3
Worry or feel anxious	1	2	3

Feel over cautious or pessimistic	1	2	3
Experience rapid heartbeat or palpitations	1	2	3
Feel flat mood or depressed	1	2	3
Feel like you've lost your sense of humour	1	2	3
Feel like crying for no reason	1	2	3
Find it difficult to relax	1	2	3
Often feel tired or overworked	1	2	3
Find it hard to get up or become motivated in the morning	1	2	3
Regularly get adequate sleep (at least 7 hours)	1	2	3
Do you have difficulty getting to sleep (more than 30 minutes)	1	2	3
Do you wake frequently through the night?	1	2	3

Immunity / Lymphatics

Do you suffer from….

Frequent colds or other infections (such as urinary)	1	2	3
Dark areas on cheeks or under eyes	1	2	3
Difficulty seeing at night	1	2	3
Regular nasal congestion, with thick mucus	1	2	3
Frequent cough or wheezing	1	2	3
Inflamed or bleeding gums	1	2	3
Cold sores or genital warts	1	2	3
Wounds heal slowly	1	2	3
Easy bruising	1	2	3
Dryness of eyes, nasal passages or mouth	1	2	3
Swollen feet or achy legs after prolonged standing	1	2	3
Enlarged glands, neck, under arm, groin	1	2	3
History of Epstein Barr, Mono, Chronic Fatigue syndrome	1	2	3

Blood Sugar regulation

Missing or delaying meals is associated with…

Increased anxiety	1	2	3
Feeling shaky, jittery	1	2	3
Palpitations	1	2	3
Weakness	1	2	3
Agitated, easily upset	1	2	3
Poor memory, forgetful	1	2	3
Mild headache	1	2	3
Lack of coordination	1	2	3
Craves sweets or stimulants	1	2	3
Irritability	1	2	3

Cardiovasacular

Over weight / obese	1	2	3
High blood pressure	1	2	3
Low blood pressure – tendency to faint	1	2	3
Palpitations	1	2	3
Episodes of shortness of breath	1	2	3
High cholesterol	1	2	3
Varicose veins	1	2	3
Smokes (or history of smoking)	1	2	3
Irregular exercise	1	2	3

Skin

Do you have….

Acne	1	2	3
Psoriasis	1	2	3
Eczema / Dermatitis	1	2	3
Rashes or hives	1	2	3
Dandruff	1	2	3
Warts	1	2	3
Tinea	1	2	3
Dry or flaky skin	1	2	3
Stretch marks	1	2	3
Excessively oily skin	1	2	3
Sensitivity to cosmetics or body products	1	2	3

Urinary system

Do you suffer from…

Regular urinary tract infections	1	2	3
History of kidney stones	1	2	3
Urine which is darker than pale yellow	1	2	3
Urinate excessively	1	2	3

Reproductive System – Female

PMS – symptoms experienced in the week or 2 prior to menstruation

• Breast tenderness, swelling	1	2	3
• Headache / migraine	1	2	3
• Food cravings	1	2	3
• Weight gain – water	1	2	3
• Mood changes - Depressed, irritable, anxious, weepy	1	2	3
• Insomnia	1	2	3
Vaginal dryness	1	2	3
Painful intercourse	1	2	3
Greenish, yellow, or offensive vaginal discharge	1	2	3
Low sex drive	1	2	3
Breast lumps	1	2	3
Excess hair (face or body)	1	2	3
Recurrent thrush	1	2	3
Absence of menstrual flow for 3 or more months	1	2	3
Irregular intervals between periods	1	2	3
Menstrual cycle longer than 32 days	1	2	3
Menstrual cycle less than 24 days	1	2	3
Scanty menstrual blood flow (or bleeding for less than 3 days)	1	2	3
Heavy menstrual blood flow (or bleeding more than 6 days)	1	2	3
Unable to become pregnant (trying more than 12 months)	1	2	3
Previously experienced a miscarriage	1	2	3
Urinary incontinence	1	2	3
Menopausal symptoms–eg sweating, mood changes,	1	2	3
History of abnormal PAP smear results	Y		N
Diagnosed sexually transmitted disease	Y		N
Diagnosed reproduction disease – endometrisos, pcos	Y		N

Reproductive System – Male

Low sperm count, low sperm motility	1	2	3
Infertile	1	2	3
Rash or itching around inner thigh or groin	1	2	3
Low sex drive	1	2	3
Premature ejaculation	1	2	3
Difficulty getting or sustaining an erection	1	2	3
Frequent urination	1	2	3
Interruption of urine stream or reduced flow	1	2	3
Difficulty in starting / finishing urination	1	2	3