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HEALTH APPRAISAL QUESTIONNAIRE

NAME: _____ **DATE**:_____

Directions

Your answers to this health questionnaire will assist me in gaining information about your current and past symptoms and health concerns. Please answer all questions in each section. The questionnaire asks you to assess how you have been feeling **during the last six months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. You may note that some questions are repeated throughout the questionnaire. I would appreciate it if you can answer **all question**s, as this will ensure the most accurate interpretation of your results. You may however leave a question blank if you are unsure of the answer. Take all the time you need to complete it.

For each question circle the number that best describes your symptoms:
0 = No or Rarely — You have never experienced the symptom or it is familiar to you but you perceive it as insignificant (e.g. monthly or less)
1 = Occasionally — Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger
4 = Often — Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it
8 = Frequently — Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis
Some questions require a YES or NO response: NO = 0 / YES = 8

All case history and medical information recorded on this form and during the consultation are kept strictly confidential. Information in this questionnaire and other patient files will not be released to any person or agency except with your authorisation or where required by law.

Main health concerns / symptoms

Health concern (describe in detail)	Severe / Moderate / Mild	Year of onset

List current medications, vitamins, minerals, herbs etc. Include contraceptive & medications taken regularly (e.g. antacids or aspirin)

Name of medication / supplement (include brand names)	Dose per day (e.g. 30g or 2/day)	Duration taken (e.g. 3 months)	Reason(s) (e.g. for acne)	Does it help? No moderately/ markedly

Have any other family members had similar health issues (describe)

Family member (e.g. mother)	Health issue	Duration

What other therapies have you had so far? e.g. doctor's advice, diet modification, homeopathy, acupuncture, chiropractic etc

Treatment type	Duration	Does/did it help? (No / moderately / markedly)

Laboratory tests performed in the past 6-12 months e. g. blood tests, stool analysis, hair analysis, any other relevant tests

Laboratory / other tests	When / Date	Outcome

Please bring copies of all tests performed in the last 6 months at a minimum

Major hospital procedures – surgeries, injuries etc. Please list all procedures done and complications (if any)

Surgery / Illness / Injury	Year	Outcome

Your past medical conditions - childhood and adulthood

Childhood (ear infections, measles, frequent antibiotics etc) Adulthood (asthma, hepatitis, diabetes etc)	Accidents or injuries in the last 5 years and major incidents before that.

Family medical history (all known illnesses e.g. heart disease, high blood pressure, cancer, diabetes, allergies, etc

Relationship	Age (if deceased, age at death)	Health issue
Mother		
Father		
Siblings		
Children		
Grandmothers		
Grandfathers		

Do you consider yourself ☐ underweight ☐ overweight ☐ just right **Your current weight** _____& height _____

Have you had an unintentional weight loss or gain of 5kg or more in the last three months? ☐ Yes (please explain) ☐ No

_____

Have you had a weight gain of more than 10kg or more in the past 12 months? ☐ Yes (please explain) ☐ No

_____

Are you sensitive or allergic to any of the following?

- ☐ Any medications (e.g. penicillin, aspirin etc) _____
- ☐ Any foods or supplements _____
- ☐ Any chemicals (including perfumes) _____
- ☐ Environmental factors (e.g. pollens, pesticides, moulds) _____

How often did you take antibiotics?

- ☐ In infancy/ childhood? _____
- ☐ As a teen? _____
- ☐ As an adult? _____
- ☐ When was the last time you have had antibiotics? _____

Do you have mercury amalgam fillings? If yes, how many and how long for?

_____

Is/ was your job associated with potentially harmful chemicals (e.g. pesticides, radioactivity, solvents). If yes, please explain

_____

Did you ever live in a house with mould on the walls? If yes, please provide details

_____

Have you lived or travelled overseas in the past? If yes, when and where?

_____

Have you experienced any major losses or any major changes in life in the past 5-10 years? If yes, please comment

_____

_____

At what point in life did you feel best? Why?

_____

_____

_____

_____

Please provide any other information you think would be helpful to address your health concerns.

_____

_____

_____

No or rarely = 0	Occasionally = 1	Moderately/Often = 4	Frequently/Daily = 8

DIGESTIVE SYSTEM

Stomach – Hypoacidity (max 48)

Indigestion, food repeats on you after eating	0	1	4	8
Excessive belching, burping	0	1	4	8
Bloating or fullness commencing during or shortly after a meal	0	1	4	8
Sensation of food sitting in stomach for a prolonged period after a meal	0	1	4	8
Bad breath / bad taste in your mouth	0	1	4	8
Skip meals or eat erratically because of loss of appetite or nausea	0	1	4	8
Small amounts of food fill you up immediately	0	1	4	8
	TOTAL:			

Stomach – Hyperacidity (max 90)

Stomach pain, burning or aching, 1-4 hours after eating	0	1	4	8
Feeling hungry just an hour or two after eating	0	1	4	8
Indigestion or heartburn from spicy or fatty food, citrus, alcohol, or caffeine	0	1	4	8
Stomach discomfort or pain in response to strong emotions, thoughts, or smell of food	0	1	4	8
Heartburn aggravated by lying down or bending forward	0	1	4	8
Difficulty or pain when swallowing	0	1	4	8
Antacids, carbonated beverages, milk, cream or food relieve the above symptoms	0	1	4	8
Black tarry stools	0	1	4	8
Vomiting blood or vomitus has appearance of coffee-grounds	0	4	8	10
	TOTAL:			

Small intestine & pancreas (max 64)

Indigestion, bloating and fullness for several hours after eating	0	1	4	8
Abdominal cramps or aches	0	1	4	8
Diarrhoea (loose, watery or frequent bowel movements)	0	1	4	8
Constipation (requiring straining, or a hard, dry or small stool)	0	1	4	8
Alternating constipation and diarrhoea	0	1	4	8
Excessive passage of gas	0	1	4	8
Undigested food in stools	0	1	4	8
Stools greasy, smelly or stick to toilet bowl	0	1	4	8
	TOTAL:			

Large intestine (max 72)

Lower abdominal pain, cramping and/or spasms	0	1	4	8
Lower abdominal pain relieved by passing gas or stool	0	1	4	8
Excessive gas and bloating	0	1	4	8
Certain foods or stress aggravate lower abdominal pain	0	1	4	8
Alternating diarrhoea and constipation	0	1	4	8
Generally constipated or straining during bowel movement	0	1	4	8
Red blood with bowel movement	0	1	4	8
Rectal pain or cramps	0	1	4	8
Mucus or pus in stool	0	1	4	8
	TOTAL:			

Never / No = 0	Occasionally = 1	Moderately / Often = 4	Frequently / Daily =8

Liver & gallbladder (max 106)

Excessive belching or gas	0	1	8	10
Fatty foods cause indigestion or nausea	0	1	4	8
Nausea and/or vomiting	0	1	4	8
Do you have pain, tenderness or soreness under your rib cage on your right	0	1	4	8
Unexplained itchy skin or feet, usually worse at night	0	1	4	8
Headache over eye(s)	0	1	4	8
Yellowish discolouration of skin or eyes, or dark coloured urine	0	1	4	8
Pain between shoulder blades	0	1	4	8
Easy intoxicated after drinking wine	0	1	4	8
Very strong body odour	0	1	4	8
Stool colour alternates from pale clay-colour to normal brown	0	1	4	8
Sensitive to chemicals-perfume, cleaners	0	1	4	8
Bitter taste in mouth, especially after meals	N			Y (8)
	TOTAL:			

ENDOCRINE SYSTEM

Thyroid – Underactive (max 96)

Fatigue, sluggishness	0	1	4	8
Feeling cold or chilled – hands & feet	0	1	4	8
Swelling or tightness in front of neck	0	1	4	8
Excessive hair loss or coarse hair	0	1	4	8
Weight gain for no apparent reason	0	1	4	8
Constipation	0	1	4	8
Dry skin and hair, brittle nails	0	1	4	8
Upper eyelid look swollen	0	1	4	8
Puffy face, hands and feet	0	1	4	8
Outer third of your eyebrow is thinning or disappearing	0	1	4	8
Low mood / Seasonal sadness	0	1	4	8
Difficulty concentrating, poor memory	0	1	4	8
	TOTAL:			

Thyroid – Overactive (max 80)

Feeling hot, or intolerance to heat, sweaty. Flush easily	0	1	4	8
	0	1	4	8
Swelling or tightness in front of neck	0	1	4	8
Diarrhoea (loose, watery or frequent bowels	0	1	4	8
Weight loss, possibly with increased appetite	N			Y (8)
Visual disturbance, problems with eyes, or development of staring gaze	0	1	2	8
Heart palpitations	0	1	4	8
Nervousness, irritability, restlessness, racing mind	0	1	4	8
Tremor (hands) / Insomnia	0	1	2	8
Light, infrequent or absent menstrual periods	0	1	2	8
Nervous, emotional, can't work under pressure	0	1	2	8
	TOTAL:			

Never = 0	Occasionally = 1	Moderately/Often = 4	Frequently/Daily = 8

Stress and adrenals (max: 128)

Feeling stressed, nervous, tense, or unable to relax	0	1	4	8
Feeling irritable or oversensitive	0	1	4	8
Feeling overwhelmed, unable to cope	0	1	4	8
Low mood, mood swings	0	1	4	8
Difficulty concentrating or thinking clearly, memory problems, brain fog (highlight relevant)	0	1	4	8
Need coffee, tea, tobacco, sugar or chocolate as pick me ups	0	1	4	8
Fatigued, tire easily. Lingering mild fatigue after exertion or stress	0	1	4	8
Find it hard to get up and going in the morning. Tend to be a "night person"	0	1	4	8
Craving for salty food	0	1	4	8
Insomnia / difficulty falling asleep	0	1	4	8
Palpitations or chest pain	0	1	4	8
Nausea, dizziness	0	1	4	8
Chronic back pain, worse with fatigue	0	1	4	8
Headache after exercise	0	1	4	8
Low blood pressure	0	1	4	8
Dizzy when standing up suddenly	0	1	4	8
	TOTAL:			

CARDIOVASCULAR SYSTEM (max 88)

High blood pressure (last reading _____) Since when? _____	N			Y(8)
Chest pain / tightness	0	1	4	8
Aware of heavy and/or irregular breathing	0	1	4	8
Shortness of breath with moderate exercise	0	1	4	8
Ankles swell especially at end of day	0	1	4	8
Blush or face turns red for no apparent reason	0	1	4	8
Dull pain or tightness in chest	0	1	4	8
Muscle cramps with exertion	0	1	4	8
Cold hands & feet	0	1	4	8
"Air hunger" or sigh frequently	0	1	4	8
Compelled to open windows in a closed room	0	1	4	8
	TOTAL:			

IMMUNE SYSTEM (max 80)

Immunity

Frequent colds or flu	N			Y(8)
Frequent infections in other locations (e.g. bladder, skin, sinus, ear, kidney etc)	N			Y(8)
Neck, armpit or groin swelling	0	1	4	8
Wounds heal slowly	N			Y(8)
Nasal congestion or discharge	0	1	4	8
Sore throat (unexplained)	0	1	4	8
Cough with mucus	0	1	4	8
Cold sores	0	1	4	8
History of Epstein Bar, herpes, chronic fatigue Shingles, hepatitis etc. Select relevant or comment	N			Y(8)
Cysts, boils, rashes	0	1	4	8
	TOTAL:			

Never = 0	Occasionally = 1	Moderately / Often = 4	Frequently / Daily = 8

Allergies – symptoms (max 88)

Nasal or sinus congestion	0	1	4	8
Red ears / hot or burning earlobes	0	1	4	8
Migraine or non-migraine headache	0	1	4	8
Sensitivity to light (skin or eyes)	0	1	4	8
Dark circles under eyes	0	1	4	8
Swollen eyes, lips, face, or other body parts	0	1	4	8
Localised or general itching – eyes, ears, throat, nose, skin	0	1	4	8
Rashes / eczema / hives (circle relevant)	0	1	4	8
Clear watery discharge from nose or eyes	0	1	4	8
Sneezing, coughing or wheezing	0	1	4	8
Certain foods worsen symptoms, or cause palpitations	N			Y (8)
	TOTAL:			

DETOX (max 64)

None=0 / Mild=1 / Moderate=4 / Severe=8

As far as you are aware, do you have a sensitivity or allergy to……

Caffeine – coffee, caffeinated drinks	0	1	4	8
Preservatives e.g. sodium/potassium benzoate / MSG / Other	0	1	4	8
Chemicals such as perfumes, exhaust fumes, cigarette smoke or other	0	1	4	8
Even small amounts of alcohol	0	1	4	8
Any foods? (give details)	N			Y (8)
History of exposure to chemicals herbicides, insecticides, pesticides or organic solvents?	0	1	4	8
Artificial/ food colourings	0	1	4	8
Have you ever taken recreational drugs?	N			Y (8)
If yes, name of the drug:				
	TOTAL:			

GLUCOSE METABOLISM (max 136)

Crave sweets	0	1	4	8
Binge or uncontrolled eating	0	1	4	8
Excessive appetite	0	1	4	8
Crave coffee or sugar in the afternoon	0	1	4	8
Sleepy in the afternoon	0	1	4	8
Fatigue that is relieved by eating	N			Y(8)
Headache if meals skipped or delayed	0	1	4	8
Irritable before meals	0	1	4	8
Shaky if meals delayed	0	1	4	8
Family members with diabetes	N			Y(8)
Frequent thirst	0	1	4	8
Frequent urination	0	1	4	8
Awaken a few hours after falling asleep, hard to get back to sleep	0	1	4	8
Extra weight in abdominal region	N			Y(8)
Tingling sensation in your hands	0	1	4	8
Slow skin healing or skin tags	N			Y(8)
Feel itchy all over	0	1	4	8
	TOTAL:			

FEMALE REPRODUCTIVE SYSTEM

Are you currently:				
Pregnant	N			Y
Menopausal	N			Y

Is your cycle (chose relevant)
Irregular
Regular (20-26 days)
Between 27-30 days
Between 30-35 days

How long is your period (chose relevant)
1-4 days
4-7 days
7-10 days
Other

Blood flow (chose relevant)
Heavy & dark
Heavy & clots & dark
Moderate
Spotting
Light
Mid cycle pains/spotting
Cramps
Backache

Dysfunctions (chose relevant)
Genital herpes
Thrush / Candida
Endometriosis
Cervical dysplasia
Uterine cysts
Fibroids
Infertility
Hysterectomy
Pelvic inflammatory disease
Other

Sexually active?	N		Y

Method of contraception (chose relevant)
The pill – name?
IUD
Condoms
Diaphragm
Rhythm
Mucus methods
Other

Pregnancies / births(provide details)

Period pain (chose relevant)
Incapacitating
Severe
Moderate
Slight
None
If yes, how many days before your cycle do symptoms begin to manifest

Do you have PMS symptoms?	N			Y
PMS-A (chose relevant) (max 32)				
Nervous tension	N			Y(8)
Mood swings	N			Y(8)
Irritability	N			Y(8)
Anxiety	N			Y(8)
	TOTAL:			
PMS-C (chose relevant) (max 48)				
Headache	N			Y(8)
Craving for sweets	N			Y(8)
Increased appetite	N			Y(8)
Heart pounding	N			Y(8)
Fatigue	N			Y(8)
Dizziness or fainting	N			Y(8)
	TOTAL :			
PMS-D (chose relevant) (max 32)				
Depression	N			Y(8)
Forgetfulness	N			Y(8)
Crying	N			Y(8)
Confusion	N			Y(8)
Insomnia	N			Y(8)
	TOTAL :			
PMS-H (chose relevant) (max 32)				
Weight gain	N			Y(8)
Swelling of legs and hands	N			Y(8)
Breast tenderness	N			Y(8)
Abdominal bloating	N			Y(8)
	TOTAL:			

Menopause (where applicable)
Last period date

Symptoms (chose relevant) (max 120)				
Sudden hot flashes	0	1	4	8
Spontaneous sweating / night sweats	0	1	4	8
Difficulty sleeping	0	1	4	8
Nervousness / irritability	0	1	4	8
Depression, anxiety, low mood	0	1	4	8
Memory problems, mental fogginess	0	1	4	8
Inability to concentrate	0	1	4	8
Numbness, tingling or prickling sensations	0	1	4	8
Skin, hair, eyes, vagina feel dry	0	1	4	8
Joint pain	0	1	4	8
Headache / Migraines	0	1	4	8
Heart palpitations	0	1	4	8
Fatigue	0	1	4	8
Dizziness	0	1	4	8
Osteoporosis	0	1	4	8
	TOTAL:			

Current symptom management
HRT
Bio identical hormones
Other
None

How is your sex drive (libido): ☐ Fine ☐ Low

Additional comments

NUTRITION AND LIFESTYLE OVERVIEW

NUTRITION (to be discussed in more detail at consultation))

Are you currently on a special diet? If so, please indicate below

- ☐ Mixed food diet (animal & vegetable sources)
- ☐ Vegetarian
- ☐ Vegan ☐ Raw (what %?)
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Carbohydrate restriction
- ☐ Paleo ☐ Paleo autoimmune
- ☐ Blood type
- ☐ Other (name/details) _____

_____

Specific food restrictions

☐ Dairy ☐ Wheat ☐ All gluten ☐ Eggs ☐ Soy
☐ Grains (specify below) ☐ Sugar ☐ Nuts (which _____
☐ Other _____

Which of the following foods do you consume regularly?

☐ **Alcohol**:
Wine glasses / week _____ Liquor glasses/week _____
Beer glasses/week_____
☐ **Caffeine**: Coffee cups/day _____ Tea cups/day _____
☐ **Water: glasses/ day** _____
☐ Filtered ☐ Tap water

Other:

☐ Soft drinks/ day ____ ☐ Dairy (milk, milk drinks)/ day _____
☐ Fast /take away food/ week _____

What percentage of your meals are home-cooked:

☐ 10-20 ☐ 30-40 ☐ 50 ☐ 60-70 ☐ 80-90 ☐ 100
If less than 70%, please indicate why? (e.g. lack of time, need to learn)

_____

Do you buy/ eat organic food? ☐ Yes ☐ No
If yes, how many meals per week are 100% organic ____ Mixed ____
☐ Organic meat ☐ Organic dairy ☐ Organic fruit & veggies

Eating patterns

Number of servings per day of:

- ☐ Fruit _____
- ☐ Dark green/yellow/orange/red vegetables _____
- ☐ Grains incl bread_____
- ☐ Beans / legumes _____
- ☐ Dairy_____
- ☐ Eggs _____
- ☐ Red meat & poultry_____
- ☐ Fish _____

Meal frequency

- ☐ Skip meals – which ones? / why?

_____

- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ More than 3 meals/day
- ☐ Graze (small frequent meals)
- ☐ Eat constantly whether hungry or not
- ☐ Snack between meals – morning / afternoon / evening

Are there any foods you crave? If so, please explain

_____

Which foods do you avoid and why? _____

LIFESTYLE

- ☐ Smoking: Present / Past (circle one). Cigarettes per day _____
- ☐ Have you ever taken recreational drugs ☐ Yes ☐ No
- ☐ Being in nature (park, garden, beach), how many days per week? _____
- ☐ Sunbathing / getting sun on the skin for at least 30min per day, how many days per week? _____

EXERCISE

- ☐ 5-7 days per week
- ☐ 3-4 days per week
- ☐ 1-2 days per week
- ☐ 45 min or more per workout
- ☐ 30-45 min per workout
- ☐ Less than 30 min
- ☐ Walking days/ week _____
- ☐ Running, jogging, other aerobic days/ week _____
- ☐ Weight lifting days/ week _____
- ☐ Yoga / Pilates days/ week_____
- ☐ Other _____

STRESS MANAGEMENT

Rate your stress levels at work (1-5=highest) 1 2 3 4 5
Rate your stress levels at home (1-5=highest) 1 2 3 4 5
Rate your job satisfaction (1-5=highest) 1 2 3 4 5
How do you handle stress? Do you practice any stress relief technique such as meditation, hobbies etc
☐ Yes ☐ No If yes, please describe

_____

_____

ENERGY LEVELS

Average energy levels during the day (1-5=highest) and when

AM: 1 2 3 4 5
PM: : 1 2 3 4 5

_____

SLEEP

How many hours of sleep per night on average: _____
Fall asleep easily: ☐ Yes ☐ No
Wake up during the night: ☐ Yes ☐ No If yes, what time?_____
Insomnia ☐ Yes ☐ No
Sleep apnoea ☐ Yes ☐ No
Other: _____

MOODS AND MENTAL HEALTH

What feelings/ emotions do you most often experience in your life:

☐ Joy ☐ Happiness ☐ Contentment/ feeling good about life

☐ Anger ☐ Sadness ☐ Fear ☐ Anxiety ☐ Worry ☐ Depression

☐ Treated for emotional issues? If yes, please elaborate further

_____

_____

WHAT IS YOUR BLOOD TYPE? (if known):

☐ A ☐ Rh+ / ☐ Rh-
☐ B ☐ Rh+/ ☐ Rh-
☐ AB ☐ Rh+ / ☐ Rh-
☐ O ☐ Rh+ / ☐ Rh-

Additional comments:

CONTEXT OF CARE QUESTIONNAIRE

One of the most important things you can do to develop new daily practices and habits is to understand your readiness to make the necessary changes and improvements. In addition, as your therapist, it's useful for me to understand how willing you are to adopt practices, as slowly or as quickly as it feels right for you.

Please answer the questions below or select the response most appropriate to your situation.

List your top three priorities in life

1)_____

2)_____

3)_____

What are your current top 4 health and lifestyle goals?

1)_____

2)_____

3)_____

4)_____

How do you rate your present level of health? Rate 1-10. 10 being excellent (……..)
Comments_____

How do you rate your present energy levels? Rate 1-10. 10 being excellent (……)
Comments_____

How do you rate your present lifestyle? Rate 1-10. 10 being excellent (…….)
Comments_____

Are you willing to change your diet to achieve your goals?
Yes (……) No (……) Maybe (…….) Rate your willingness (1-10=highly committed) (…….)
Explain_____

_____

If presented with information on diet, relaxation or lifestyle that contradicts what you currently believe, what approach would you take?
Keep an open mind and give it a try (……) Ask a friend (…….) Ignore the advice (…….) Other
Explain_____

Are you willing to change your lifestyle habits? (sleep, exercise, relaxation, smoking, drinking, junk food etc)
Yes (…….) No (…….) Maybe (…….) Rate your willingness (1-10=highly committed) (……)
Explain _____

Are you willing to modify / increase your exercise level/ frequency?
Yes (…….) No ( ) Maybe (…….) Rate your willingness (1-10=highly committed) (…….)
Explain_____

Are you willing to undertake stress management, relaxation and/or spiritual practices? (e.g. meditation)
Yes (……..) No (……..) Maybe (……..) Rate your willingness (1-10=highly committed) (…….)
Explain _____

Do you think your family and friends will be supportive of you making health and lifestyle changes necessary to improve your health and quality of life? Please elaborate

_____

_____

When did you have your last holiday of more than one week?
Comment _____

What level of personal stress are you experiencing in your life right now? Rate 1-10.10 being highest. (…….)
What are the major causes of stress (e.g. poor health, work, home situation, finances etc)

_____

_____

_____

How confident are you in your ability and willingness to persevere with the nutrition, lifestyle and exercise modifications most likely required for you to achieve good health and wellbeing?
Rate 1-10. 10 being highly confident (……)
Explain _____

_____

How long do you feel it would take you to achieve your health and lifestyle goals?
Weeks (……..) Months (…….) Years (…….)
Explain _____

_____

<u>What</u> do you think could stop you from achieving your health goals?
Lack of time (…) Lack of commitment (….) Lack of support (……) Money (……) Interest (…) Other
Explain_____

_____

Finally, Why you might want to achieve the goals for yourself?
Comment _____

_____

_____

_____

_____

Thank you for taking the time to fill out the Health Appraisal Questionnaire and provide me with details of your health, medical history and goals. If possible, please send/ email this document back to me before our consultation to discuss it.