

Date of appointment (if known):

Health questionnaire - **confidential**

PLEASE complete and return this form **at least 3 working days** it **in advance** of your first appointment. **USE BLACK INK AND WRITE CLEARLY IN A LARGE PRINT.** If you run out of space, please use a separate piece of paper. Please staple the sheets together and ensure your FULL NAME is on every sheet. Thank you.

This information will be used for your healthcare ONLY. I do not pass on your details.

Today's date	
Full Name	
Full address	
Postcode	
Home Tel.	
Work Tel.	
Mobile	
E-mail	
Date of birth	
Age	
Sex	Female / Male
Marital status	Single / Living with partner / Married / Divorced / Widowed
Guardian (if child)	
Partners name	
Next of kin	
Living arrangements	Alone / With partner / With partner or spouse & children / With parents / With housemates or flatmates / With grown up child(ren)
Family size	
GP & practice	
Religion	
Consultants & specialities	
Occupation	
Height	
Weight	
Pref. weight	
Weight change?	

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Have you seen a dietitian (or nutritionist) before? Who, when and where?

Are you seeing any other therapists? e.g. chiropractor, physiotherapist, etc

If female, are you pregnant or aiming to become pregnant?

Are you currently following any type of diet? If so, please give details below:

Is this a self-imposed diet?

Where did you obtain the information from?

Current health & nutrition concerns – please list

Health or nutrition concern	Main symptoms	Duration / frequency	Treatment / medication	Dates

Mental / emotional health

How would you describe your current mental health?

Do you suffer from anxiety or panic attacks? Please give details

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Medical history & hospitalisations – please list

Health problem	Duration	Medication / investigations	Date

Do you have any food allergies or intolerances? Please list all known and include details of any symptoms

Are you allergic or intolerant to any medications? Please list all known and include details of any symptoms

Are you allergic or intolerant to anything else? For example pollen, house dust mites? Please list all known and include details of any symptoms

Please tick if you are allergic to cats

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Current medications? – Please list all

Name of medication	Dose	Taken for?	How long have you taken this for? (years)

Nutritional supplements? - Please list all

Supplement	Manufacturer	Dose?	Reason you take?

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Herbal or other remedies? - Please list all

Herbal remedy	Manufacturer	Dose?	Reason you take?

**Family medical history? – please list known conditions
(e.g. diabetes, heart disease, etc)**

Mother		Maternal Grandmother	
		Maternal Grandfather	
Father		Paternal Grandmother	
		Paternal Grandfather	
Aunt		Uncle	
Sister		Brother	

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Toxicity profile – please circle or write in answers

Smoking	Smoker – yes / no Previously smoked – yes / no How many years did you smoke?
Alcohol?	Do you drink? – yes / no Have you ever drunk heavily? Do you regularly drink to excess currently or are you concerned about your alcohol intake? – yes / no
Street drugs?	Do you use street drugs such as cannabis? yes / no What do you use?
Dental history?	How many amalgam (silver) fillings do you have? What condition would you say your teeth are currently in?
Environmental toxins and exposure to chemicals	Do you work with any potentially toxic chemicals such as paints, solvents, fuels, oils, dry cleaning fluids, etc. Have you had any exposure in the past? Please list all known here:
Do you buy organic foods? How often?	
Do you check your personal care products such as makeup, aftershave for toxic ingredients such as parabens, triclosan, aluminium, etc?	
Do you check your household products for toxic ingredients?	
Do you actively seek to purchase greener, cleaner products?	

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Quick symptom scan

Underline, **circle** or **highlight** any that apply to you. Feel free to add additional things.

Head

Headaches, migraine, neck / back / posture problems, dizzy, poor balance, brain 'fog', poor memory, forgetful, poor concentration, I spend a lot of time working at a computer, I spend a lot of time sitting

Hair

Oily, dry, brittle, poor condition, dandruff, thinning hair, bald patches, increased facial hair,

Nails

Brittle, flaking, peeling, splitting, hangnails, spoon shaped, white spots, horizontal white lines

Eyes

Burning, puffy, sticky, itchy, gritty, poor night vision, dry, cataracts, sensitive to light, eye bags, blurred vision, double vision, yellowish, long sighted, short sighted, Sjogren's syndrome

Ears

Blocked, overly waxed, poor hearing

Nose

Stuffy, congested, frequent nose bleeds, prone to snoring, sinusitis, hay-fever, post-nasal drip, rhinitis, poor sense of smell

Muscles

Tender, sore, poor muscle tone, wasting, weak, stiff, frozen, 'restless legs', cramps, numbness

Skin prone to

Dry, rough, scaly, pimples, rosacea, dermatitis, eczema, psoriasis, rashes, boils, hives, itching, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

Joints (Fingers, knees, back, shoulders)

Painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow-movement

Mood (Please underline your predominant states even if they conflict)

Depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, lethargic, can't be bothered, stressed, hyperactive, cheerful, agitated, easily upset, tearful, frightened, explosive, pent-up, worried, unable to relax

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Mind

Forgetful, confused, poor concentration, easily distracted, difficulty making decisions, can't switch off, apathy, fogginess, dyslexia, dyspraxia, hyperactive, panic attacks, no motivation

Chest

Frequent colds and chest infections, asthma, bronchitis, laryngitis, diagnosed heart condition, palpitations, chest discomfort/pain, short of breath, difficulty breathing, wheezing, persistent cough, noisy breathing

Chewing & swallowing

Problems with my teeth, problems with my gums, furry tongue, sore tongue, cracked tongue, oral thrush, sore throats, white patch on gums

Gut

Bloated, tender, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, pain after eating, discomfort after eating, irritable bowel syndrome (IBS), coeliac, hiatus hernia, diverticula, polyps, haemorrhoids, stomach ulcer, pain (where?) -

Bowels & stools

Stools are normal in colour, stools can occasionally be greenish / orange colour / very pale, Stools are a good solid consistency, stools like rabbit pellets, stools very variable, stools hard and compact, bowels sluggish, pain on passing stools, constipation, diarrhoea, alternating constipation & diarrhoea, my stools float in the pan and are difficult to flush

Genitals and reproductive

Itchy, cystitis, thrush, ulcers, prostatitis, pelvic inflammatory disease, impotence, painful urination, frequent urination, frequent urination at night, unexplained discharge, painful periods, irregular periods, heavy periods, monthly bloating, menopausal symptoms, PMS

Hands

Dry, cracked, sore joints, swollen knuckles, puffy, cold hands, chilblains, numbness, tingling, feel clumsy & uncoordinated, poor circulation

Legs and feet

Restless legs, swollen legs, swollen feet, athlete's foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, numb, ulcers, pressure sores

Sleep

Poor quality sleep, lack of sleep, unable to get to sleep, fell drowsy and tired on waking, wake up feeling terrible, thirsty at night, my partner or child is a poor sleeper which ruins my sleep

Physical activity

Lots & regularly, a little regularly, a little but could do more, very little, virtually no exercise taken

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Please tick the appropriate boxes and sign below:

I understand that payment for appointments must be made **on the same day as the appointment**. I have read and understand the cancellation policy. An appointment will NOT be offered to you without your dated signature below.

I understand that my data will be used for patient care and administrative purposes only. (Note that, I do **not** share your details with anyone other than health professionals involved in your care. I assume I have your permission to contact your GP. If you do NOT wish me to contact your GP for any reason, please tick the box below.

Please do not contact my GP

If you would like to be added to my mailing list for future talks / newsletter(s) please tick this box. I do regular FREE health related talks. You are cordially invited to attend if you wish.

Signed:

Date:

PLEASE remember to bring everything to your appointment, for example, results of tests, medications (in original packaging), nutritional supplements, diet sheets, food items, etc.

You can return these sheets by email to advice@shem.im, or post to:

Ms Shem Allanson, c/o Thie Eden, Ballamona Road, Ballaugh, Isle of Man. IM7 5BE