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Nutritional Therapy Questionnaire 2007

This questionnaire will help me know a little more about you in order to assess how best to improve your health. Please answer all the questions regardless of whether you think they may be relevant or repetitive. Bring this questionnaire with you to your appointment, you do not need to email or post it.

Name Mr/Miss/Ms/Mrs		Date of Appointment.	
		Mobile no.	
Address		Tel: (work)	
		Tel: (home)	
		Email address: Is it private?	

Occupation		Age, and DOB	
		Weight	
Your GP's name and address		Height	
		Blood pressure	O / A / B / AB +/-
		Blood Group	
Please sign to give permission to contact your GP if necessary.			
If you are seeing another therapist it may help if we can communicate and work together on your case. Please name the therapist and sign to affirm.			

MEDICAL HISTORY	
Please list your main health problems, and how long you have had them.	
Health Problem	Duration Eg: 2 years
Eg. Migraine	
What seems to help these problems?	
What seems to make these problems worse?	

MEDICAL HISTORY	
What past illnesses have you had and how old were you?	
Give details of any abnormal test results you have had, and ages.	
Please list any other treatments you have had for these problems, including medicines.	
How long have you been on medication?	
Have you ever been prescribed antibiotics for long periods of time?	
Please give details of any serious accidents you have had, ie burns, falls, or broken limbs, and how old you were.	
Have you had any operations? (include terminations, removal of wisdom teeth, tonsils, adenoids)	

EARLY LIFE	
What was your birth weight?	
Were there any defects noted at birth?	
Was development normal after birth?	
Were you breast-fed? If so, for how long?	
Did the mother have health problems while pregnant? Were medicines used?	
Was there much nausea in the pregnancy?	
Did the mother smoke or drink in the early part of the pregnancy?	
Did any food allergy or intolerance upset you?	
Was there any unusual bed-wetting?	
Did you, as a child ever eat non-foods ie earth, paint etc? (or still do?)	
Give details of any health problems during your infancy. Rashes, diarrhoea etc	
As a child were you ... Colicky - Excitable Discontented - Cries often - Demanding - Aggressive Restless - Hyperactive - Not a good sleeper	

DRUG PROFILE	
Are you now, or have you in the past, taken any of the following drugs? State when, and for how long?	
Antibiotics	HRT
Tranquillisers	Steroids
Other medicinal drugs	Recreational Drugs

VACCINATIONS	
Please indicate vaccinations you have had, when you had them and if you had any adverse reactions to them.	
BCG	<input type="checkbox"/> _____
Rubella	<input type="checkbox"/> _____
Cholera	<input type="checkbox"/> _____
Smallpox	<input type="checkbox"/> _____
Diphtheria	<input type="checkbox"/> _____
Tetanus	<input type="checkbox"/> _____
Influenza	<input type="checkbox"/> _____
Typohid	<input type="checkbox"/> _____
MMR	<input type="checkbox"/> _____
Whooping Cough	<input type="checkbox"/> _____
Polio	<input type="checkbox"/> _____
Yellow Fever	<input type="checkbox"/> _____
Meningitis	<input type="checkbox"/> _____
Any other vaccinations: and if so when?	

FEMALE PATIENTS ONLY	
Do you get menstrual periods now? If yes are they regular? How long is your cycle?	
Are they very painful/a bit / not too bad/not painful Heavy/light/average?	
Please list any problems that always seem to occur <u>before</u> your periods start. (Eg irritability, crying, craving sweets, bloating)	
Do you get any problems <u>during</u> your period? eg cramps, Is there any clotting?	
What contraception do you use? If you are on the contraceptive pill, how long have you taken it? If you no longer take it, when did you take it and for how long?	
Have you ever had a miscarriage? Have you ever had a termination?	
Are you trying to become pregnant? If so, length of time trying.	
Are you pregnant? If so, how many weeks?	
How many children do you have?	
Were there any problems with the pregnancy(ies)? (eg severe morning sickness, stretch marks etc)	
Do you have a regular cervical smear?	
Have you ever had breast or ovarian cysts or fibroids?	
Do you get menopausal symptoms? (Please list them)	

TOXICITY PROFILE	
Do you smoke? If yes, how many?	
If you have stopped, from what age did you smoke, and for how long?	
How many amalgam (silver) fillings do you have?	
Have you ever drunk heavily?	
Do you work with any chemicals? (eg paints, solvents, dry cleaning fluid)	
Do you regularly use aerosols or sprays?	
Do farmers often spray crops near your home?	
Do you spend much time in or near heavy traffic?	
Are you exposed to fumes in your home or place of work?	
Do you use filtered or bottled drinking water? How much do you drink?	
Approximately how many x-rays you have had?	Dental Other

YOUR LIFESTYLE	
EXERCISE Do you have a job or hobby that involves much physical activity? If not, what do you do to keep fit?	Yes / No -----
STRESS How stressful is your life? 1-10 Do you get very impatient? Do you find it very hard to say 'no' to other people? Do you tend to bottle up your feelings? Do you feel guilty when relaxing? Are there any long-term stressful situations in your life?	----- Yes / No Yes / No Yes / No Yes / No -----
<u>In the last twelve months ...</u> Has anyone close to you died? Have you divorced or separated? Have you had to leave a job? Have there been any other major changes in your family, home or work situation? Please detail.	Yes / No Yes / No Yes / No Yes / No

YOUR FOOD	
Are you following any particular dietary programme?	
Do you go out of your way to avoid foods containing preservatives or additives?	
Do you enjoy cooking?	
Do you eat food containing sugar?	
How much sugar do you add to food and drinks each day?	
How often do you eat chocolate or sweets?	
Do you add salt to your food?	
Do you normally eat fast?	
What foods do you particularly dislike?	
What foods do you particularly like? What foods do you eat a lot of?	
How many cups of tea or coffee do you drink per day? How do you drink it? With milk? What sort? With sugar? How much?	
How many glasses of alcohol do you drink per week?	
How much bread do you eat each day?	
What percentage of your flour-based food (bread, pastry, cakes, biscuits, pasta) is wholemeal?	
What percentage of your diet is fruit and vegetables?	
What percentage of your diet is raw?	
How many pints of milk do you use in a week?	
How many times a week do you eat:	Red meat? White meat? Fish?
Which foods would you have difficulty giving up?	
Please list any supplements you take regularly, giving brand names.	

YOUR SYMPTOMS	
Leave blank, if the symptom never occurs, tick if it is mild or occasional, and tick it twice if it is frequent or pronounced.	
Na/K	
Pre-menstrual tension	<input type="checkbox"/> <input type="checkbox"/>
Irritability	<input type="checkbox"/> <input type="checkbox"/>
Headaches over the eyes	<input type="checkbox"/> <input type="checkbox"/>
Sinus and chest problem	<input type="checkbox"/> <input type="checkbox"/>
Hay fever	<input type="checkbox"/> <input type="checkbox"/>
Swollen legs	<input type="checkbox"/> <input type="checkbox"/>
Lower abdomen swelling	<input type="checkbox"/> <input type="checkbox"/>
Muscle and joint ache	<input type="checkbox"/> <input type="checkbox"/>
Sleeping difficulties	<input type="checkbox"/> <input type="checkbox"/>
Itchy skin	<input type="checkbox"/> <input type="checkbox"/>
Greasy hair and dandruff	<input type="checkbox"/> <input type="checkbox"/>
Craving salty foods	<input type="checkbox"/> <input type="checkbox"/>
Recurrent colds	<input type="checkbox"/> <input type="checkbox"/>
Calcium loss from the bone	<input type="checkbox"/> <input type="checkbox"/>
Frequent morning water passing	<input type="checkbox"/> <input type="checkbox"/>
Heavy periods or miscarriages	<input type="checkbox"/> <input type="checkbox"/>
A	
Mouth ulcers	<input type="checkbox"/> <input type="checkbox"/>
Frequent colds or infections	<input type="checkbox"/> <input type="checkbox"/>
Thrush or cystitis	<input type="checkbox"/> <input type="checkbox"/>
Dry flaky skin	<input type="checkbox"/> <input type="checkbox"/>
Dandruff	<input type="checkbox"/> <input type="checkbox"/>
Itchy eyelids	<input type="checkbox"/> <input type="checkbox"/>
Poor eyesight	<input type="checkbox"/> <input type="checkbox"/>
Eyesight much worse in bad light	<input type="checkbox"/> <input type="checkbox"/>
B1	
Rapid heartbeat	<input type="checkbox"/> <input type="checkbox"/>
Eye pains	<input type="checkbox"/> <input type="checkbox"/>
Irritability	<input type="checkbox"/> <input type="checkbox"/>
Numbness or tingling	<input type="checkbox"/> <input type="checkbox"/>
B2	
Bloodshot, burning or gritty eyes	<input type="checkbox"/> <input type="checkbox"/>
Cracked lips	<input type="checkbox"/> <input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/> <input type="checkbox"/>
Sensitivity to bright lights	<input type="checkbox"/> <input type="checkbox"/>
B3	
Sore tongue	<input type="checkbox"/> <input type="checkbox"/>
Depression	<input type="checkbox"/> <input type="checkbox"/>
Burning sensations	<input type="checkbox"/> <input type="checkbox"/>
Feeling 'spaced out'	<input type="checkbox"/> <input type="checkbox"/>
B5	
Burning hands or feet	<input type="checkbox"/> <input type="checkbox"/>
Tender heels	<input type="checkbox"/> <input type="checkbox"/>
Teeth grinding	<input type="checkbox"/> <input type="checkbox"/>
Wind pains in tummy	<input type="checkbox"/> <input type="checkbox"/>
Deteriorating co-ordination	<input type="checkbox"/> <input type="checkbox"/>

B6	
Difficulty in remembering any dreams	<input type="checkbox"/> <input type="checkbox"/>
Spasms or convulsions	<input type="checkbox"/> <input type="checkbox"/>
Nausea	<input type="checkbox"/> <input type="checkbox"/>
Fluid retention	<input type="checkbox"/> <input type="checkbox"/>
Hallucinations	<input type="checkbox"/> <input type="checkbox"/>
Oily scaling skin around scalp, eyebrows or behind ears	<input type="checkbox"/> <input type="checkbox"/>
B12	
Increasing unsteadiness	<input type="checkbox"/> <input type="checkbox"/>
Increasing clumsiness	<input type="checkbox"/> <input type="checkbox"/>
Sore tongue	<input type="checkbox"/> <input type="checkbox"/>
Easy exhaustion	<input type="checkbox"/> <input type="checkbox"/>
FA	
Cracks at corner of mouth	<input type="checkbox"/> <input type="checkbox"/>
Prematurely greying hair	<input type="checkbox"/> <input type="checkbox"/>
Increasing mental confusion	<input type="checkbox"/> <input type="checkbox"/>
Trembling of hands or head	<input type="checkbox"/> <input type="checkbox"/>
C	
Swollen, tender gums	<input type="checkbox"/> <input type="checkbox"/>
Cuts and wounds slow to heal	<input type="checkbox"/> <input type="checkbox"/>
Easy bruising	<input type="checkbox"/> <input type="checkbox"/>
Slow to recover from colds and flu	<input type="checkbox"/> <input type="checkbox"/>
D	
Rheumatic pains	<input type="checkbox"/> <input type="checkbox"/>
Bone pain and tenderness	<input type="checkbox"/> <input type="checkbox"/>
Deafness	<input type="checkbox"/> <input type="checkbox"/>
Lack of sunlight	<input type="checkbox"/> <input type="checkbox"/>
Lethargy	<input type="checkbox"/> <input type="checkbox"/>
E	
Menopausal problems	<input type="checkbox"/> <input type="checkbox"/>
Varicose veins	<input type="checkbox"/> <input type="checkbox"/>
Cold sores	<input type="checkbox"/> <input type="checkbox"/>
Signs of premature ageing	<input type="checkbox"/> <input type="checkbox"/>
Age spots	<input type="checkbox"/> <input type="checkbox"/>
Ca/Mg	
Muscle cramps	<input type="checkbox"/> <input type="checkbox"/>
Muscle pains	<input type="checkbox"/> <input type="checkbox"/>
Irregular heartbeats or palpitations	<input type="checkbox"/> <input type="checkbox"/>
Severe nervousness	<input type="checkbox"/> <input type="checkbox"/>
Difficulty relaxing muscles	<input type="checkbox"/> <input type="checkbox"/>
Zn	
White spots on fingernails	<input type="checkbox"/> <input type="checkbox"/>
Poor appetite	<input type="checkbox"/> <input type="checkbox"/>
Stretch marks on skin	<input type="checkbox"/> <input type="checkbox"/>
Hair very slow to grow	<input type="checkbox"/> <input type="checkbox"/>
Unusual loss of hair	<input type="checkbox"/> <input type="checkbox"/>
Deteriorating sense of taste or smell	<input type="checkbox"/> <input type="checkbox"/>
Eczema or spotty skin	<input type="checkbox"/> <input type="checkbox"/>
Alcohol or substance addictions	<input type="checkbox"/> <input type="checkbox"/>

Fe: Anaemia or constant tiredness	<input type="checkbox"/> <input type="checkbox"/>
Severe heart pounding after a little exercise	<input type="checkbox"/> <input type="checkbox"/>
Pale skin	<input type="checkbox"/> <input type="checkbox"/>
EFA imb: Dizziness	<input type="checkbox"/> <input type="checkbox"/>
Convulsions	<input type="checkbox"/> <input type="checkbox"/>
EFA: Rough, dry skin	<input type="checkbox"/> <input type="checkbox"/>
History of ear problems	<input type="checkbox"/> <input type="checkbox"/>
Excessive thirst	<input type="checkbox"/> <input type="checkbox"/>
Dry eyes	<input type="checkbox"/> <input type="checkbox"/>
Split or brittle nails	<input type="checkbox"/> <input type="checkbox"/>
Difficulty putting on weight	<input type="checkbox"/> <input type="checkbox"/>
Flatulence	<input type="checkbox"/> <input type="checkbox"/>
Frequent bloatedness	<input type="checkbox"/> <input type="checkbox"/>
Much undigested food in stools	<input type="checkbox"/> <input type="checkbox"/>
Indigestion (not relieved by indigestion tablets)	<input type="checkbox"/> <input type="checkbox"/>
Bowel movements less than once a day	<input type="checkbox"/> <input type="checkbox"/>
Bad breath or foot odour	<input type="checkbox"/> <input type="checkbox"/>
Joint pains	<input type="checkbox"/> <input type="checkbox"/>
Spotty skin	<input type="checkbox"/> <input type="checkbox"/>
Dullheadedness	<input type="checkbox"/> <input type="checkbox"/>
Nose always runny or stuffy	<input type="checkbox"/> <input type="checkbox"/>
Excess mucus	<input type="checkbox"/> <input type="checkbox"/>
Frequent sneezing	<input type="checkbox"/> <input type="checkbox"/>
Hay fever	<input type="checkbox"/> <input type="checkbox"/>
Rashes	<input type="checkbox"/> <input type="checkbox"/>
Swellings	<input type="checkbox"/> <input type="checkbox"/>
Asthma	<input type="checkbox"/> <input type="checkbox"/>
Migraine or headaches	<input type="checkbox"/> <input type="checkbox"/>
Tummy pains	<input type="checkbox"/> <input type="checkbox"/>
Frequent bloatedness (2)	<input type="checkbox"/> <input type="checkbox"/>
Diarrhoea	<input type="checkbox"/> <input type="checkbox"/>
Sinusitis	<input type="checkbox"/> <input type="checkbox"/>
Do you get itching in the anal area?	<input type="checkbox"/> <input type="checkbox"/>
Do you feel ill in damp, mouldy areas?	<input type="checkbox"/> <input type="checkbox"/>
Do smells / odours make you feel ill?	<input type="checkbox"/> <input type="checkbox"/>
Do some foods or drinks seem to disagree with you? (give details)	<input type="checkbox"/> <input type="checkbox"/>

How often do you pass a stool? Could you describe the general consistency, where 1 is hard to pass, and 7 is liquid. Refer to the Bristol Stool Chart Scale ,	
What is the colour of your urine First thing in the morning? Later in the day?	

Do you get attacks of sweating for no reason?	<input type="checkbox"/> <input type="checkbox"/>
Do your hands or feet often feel cold?	<input type="checkbox"/> <input type="checkbox"/>
When you haven't eaten for a few hours, do you ever get dizzy or shaky	<input type="checkbox"/> <input type="checkbox"/>
- become unable to think clearly	<input type="checkbox"/> <input type="checkbox"/>
- feel as if you're going to pass out?	<input type="checkbox"/> <input type="checkbox"/>
When hungry do you mainly crave sugary things?	<input type="checkbox"/> <input type="checkbox"/>
Do you ever get severe mood swings for no reason?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a high sex drive?	<input type="checkbox"/> <input type="checkbox"/>
- feel warm when others are cold?	<input type="checkbox"/> <input type="checkbox"/>
- feel cold when others are warm?	<input type="checkbox"/> <input type="checkbox"/>
Do you put on weight very easily?	<input type="checkbox"/> <input type="checkbox"/>

Palpitations	<input type="checkbox"/> <input type="checkbox"/>
Heat intolerance	<input type="checkbox"/> <input type="checkbox"/>
Nervousness	<input type="checkbox"/> <input type="checkbox"/>
Insomnia	<input type="checkbox"/> <input type="checkbox"/>
Breathlessness	<input type="checkbox"/> <input type="checkbox"/>
Increased bowel movements	<input type="checkbox"/> <input type="checkbox"/>
Light or absent menstrual periods	<input type="checkbox"/> <input type="checkbox"/>
Fatigue	<input type="checkbox"/> <input type="checkbox"/>
Fast heart rate	<input type="checkbox"/> <input type="checkbox"/>
Trembling hands	<input type="checkbox"/> <input type="checkbox"/>
Weight loss	<input type="checkbox"/> <input type="checkbox"/>
Muscle weakness	<input type="checkbox"/> <input type="checkbox"/>
Warm moist skin	<input type="checkbox"/> <input type="checkbox"/>
Hair loss	<input type="checkbox"/> <input type="checkbox"/>
Staring gaze	<input type="checkbox"/> <input type="checkbox"/>

HEALTH PROFILE
List the three most important benefits you would like to gain from this programme. 1. 2. 3. To what extent are you prepared to modify your lifestyle in order to improve your health?
Please list any forms of alternative or complementary medicine you have knowledge of.
Do you know any spiritual, meditative or relaxation techniques? If yes, which?
How many hours sleep do you need? _____ How many hours do you sleep? _____ What hours do you sleep from/to? _____ Do you have difficulty falling asleep? yes / no Or staying asleep? yes / no If you regularly wake up in the night, what time do you wake up, and when do you fall asleep? _____

Please tick any signs or symptoms that you experience. If you find that your sign/symptoms is in all three boxes, then please tick all three.

Signs and symptoms	Adrenal	Mixed	Thyroid
Body Type	Thin, can't gain weight	Gains easily, goes to tummy/hips first, very hard to lose.	Weight gain, generalized or global, extremely hard to lose
Face Shape	Eyes, cheeks sunken when severe	Normal	Full, puffy around eyes
Eyebrows	Tend to be full	Normal to sparse	Very sparse outer 1/3 to 1/2
Tissue Around eyes	Sunken appearance, may have dark circles	Normal or some "bags" under the eyes	Puffy around the eyes, often bags under the eyes
Facial Coloring	Tendency to pallor, especially around mouth. In dark skin, it darkens around mouth, forehead, sides of face	Pallor around mouth (more visible with light skin)	Ruddy or rosy complexion, including around the mouth
Hair quality	Thin and wispy. May become straw-like or straighter. Dry. Falls out easily. Sparse on forearms or lower legs.	Tendency to become sparse	Tends to be coarse, sparse, may become wavy or curly (rare) or change colour
Nails	Thin, brittle	Break easily	May be thick
Skin Quality	Dry, Thin, Finger-prints often "smoothed out" or flat/shiny and may have longitudinal wrinkles over finger pads (probable cause is low collagen level)	May be thin, dry, bruise easily, poor healing.	Poor healing, May bruise easily. Skin thickness is normal (not thin)
Pigment Distribution	Vitiligo (white spots or patches) in late stage. May tan too easily. In dark skin, darker on forehead, sides of face, around mouth and chin/jaw.	Milder version of vitiligo (tiny white spots on arms and/or legs) and dark patches if dark skin.	In pure hypothyroidism, vitiligo and hyperpigmentation are very rare.
Connective Tissue Quality (ligaments, tendons, skin, hair, and nails)	Lax ligaments or flexible (e.g. flat feet, double jointed). Joint strains/sprains are common.	Mixed	Poor flexibility
Fluids/Secretions	Dry skin, little secretions. Can't hold on to water.	Mixed, e.g. and dry body and oily face	Good secretions. Skin may be oily. Tendency to fluid retention.
Light Sensitivity or Night Blindness	++	+	-
After Image (e.g. seeing the image of a flash bulb or bright light moving by longer than others)	++	+	+/-
Typical Pains	Headaches, migraines, muscles, carpal tunnel	+ Muscles, carpal tunnel	Occasionally joints, muscles, feet/lower legs
Temperature Pattern (pls ask if you have not already had a temperature form)	Thermal chameleon (hot when it's warm and cold when it's cool). Poor thermoregulation. Tends to low body temperature around 97.8 or lower. Fluctuating pattern.	Fluctuating pattern, usually averaging 97.8 but can be lower	Stable, non-fluctuating pattern, average can be from low 90's to a little below 98.6
Cold Intolerance	+++	++	+/-
Heat Intolerance	+	++	+++
Cold Hands/Feet	+++	Happens often	-
Warm Hands / Feet (in spite of low body temperature)	-	Happens occasionally	++
Sweating	May be excessive in early phase. Poor sweating in late phase.	May appear normal	Normal to increased, more oily than 'wet'
General Reactivity: Emotional, physiological, etc.	Hyper-reactive (over)	Moderate	Hypo-reactive (under)
Immune Function	Tendency to over-react results in allergies, sensitivities, autoimmune problems	Mixed	Tendency to under-respond results in infections (sinus, bladder, bowel, skin, etc.)
History of EBV or Mononucleosis	+++	++	+/-
Sensitivity to medications, supplements etc. Needs small doses	++	+	-

Intuitive: Picks up other peoples feelings (e.g. at malls, parties).	++	+	+/-
Personality Tendency: Humour	+/-	+	++
Personality Tendency: Serious	++/+++	++	+/-
Depression	+	++	+++
Anxiety, panic attacks, worry, fear, insecurity, feelings of impending doom (any combination). "I thought I was dying..."	+++	++	+
Obsessive Compulsive	++	+	+/-
Startle Easily	++	+	=
Tolerance to Change/Stress	Poor	Poor/Moderate	Moderate
Sleep Patterns	Tendency to one or more: Insomnia, light sleeper, waking up at 2-4 AM, unrefreshing sleep	May or may not have sleep disturbance	Tendency to one or more: Sleepiness, narcolepsy, sleep apnea, unrefreshing sleep
Mental Abilities	Poor focus, clarity, concentration, short-term memory. 'Brain fog'	Poor focus, clarity, concentration, short-term memory.	Poor focus, clarity, concentration, short-term memory. 'Slow thinking'
Energy Pattern	Complains of fatigue or exhaustion, "wired and tired", can't persevere, low motivation	Variable energy that can be good or poor.	Complains of being tired, sluggish, low motivation
Exercise Tolerance	Causes fatigue. Can't persevere. If severe, body temperature drops after exercise.	Mixed	Can't exercise much. Tires easily.
Oedema (swelling), non-pitting in lower legs	-	+/-	+
Standing still is difficult or causes discomfort. Walking is easier.	+	+/-	-
Fibromyalgia / chronic fatigue	++	++	++
Orthostatic Hypotension (light-headed when getting up to stand from laying or sometimes, even sitting)	++	+/-	-
Blood Pressure	Tends to run low, e.g., from 80/50 at the low end to 110/70 at the high end	Can be low, normal or high	Ranges from normal to very high and poorly controlled by medications
Heart Palpitations ("feels like my heart was about to jump out of my chest").	++	+/-	-
Mitral Valve Murmur or Prolapse	++	+	+/-
Dietary Habits	Often lean toward being vegetarian or avoids certain foods	Tends to have fewer dietary restrictions than the pure adrenal type	Tends to eat everything
Digestion	Often has difficulty digesting meat, or other proteins. Some foods troublesome.	May be normal or difficulty with some foods.	Poor but they often think it's good.
Bowel Function	Tendency to be irritable, or hyperactive, transit time may be too fast (food exits stomach too fast causing poor [enzymatic] digestion)	Poor/mixed	Tendency to constipation, hypoactive, slow transit time (food leaves stomach too slowly) and poor mechanical digestion.
Malabsorption	+++	++	+
Cravings	Sweets, carbohydrates, salt (any combination), black licorice	Mixed	Fats
Blood sugar. (Hypoglycemia = low blood sugar. Hyperglycemia = elevated blood sugar)	Tendency to hypoglycemia. May need many small meals or "crash"	Can range from mild hypoglycemia to hyperglycemia	Normal to hyperglycemia
Problems with menses and /or fertility (females)	++	+	+/-

PLEASE ENSURE THESE TESTS ARE COMPLETED BEFORE YOUR APPOINTMENT.

SALIVA TEST: Spit into a glass of water. Does it float or sink to the bottom?
Please circle answer.

BLOOD TEST 1: If you do not know your blood group could you purchase a home testing kit. These are available at a variety of health food shops, Fresh and Wild and The Nutricentre. Follow the instructions contained in the pack and please record your blood group. -----

BLOOD TEST 2: If you have done Blood Test 1, draw a few extra drops of blood and drop it into a glass of water.
If you have not done Blood Test 1, then purchase a sterile needle from a local chemist. Prick the end of one finger to get a few drops of blood into a glass of water. Does it float or sink to the bottom? Please circle answer.

THYROID TEST: Immediately you wake up, place a thermometer under the arm and retain for 10 minutes before checking. Try to do this at the same time for each of three consecutive days. (Do not get out of bed to go to the loo or find the thermometer, or the use of your muscles can artificially raise your temperature.)

1. Three hours after waking, place the thermometer in your mouth to check the temperatures and then again at six hours and nine hours. For example if you wake at 7.30am the mouth temperature is checked at 10.30am, 1.30pm and 4.30pm.
2. Men, and women who are pre-pubescent or post-menopausal, can check their temperature on any three days. For menstruating women the temperature is best measured on days 2, 3 and 4 of their period.
3. Do not talk or move until the test is completed.

This test is not a definitive test but the information will be used in conjunction with other methods of diagnosis to provide an indicator of hypothyroidism and offers a valuable means to monitor your progress under treatment.

Date	Time	Temperature upon waking (under arm)	Temperature 3 hours later (mouth)	Temperature 6 hours later (mouth)	Temperature 9 hours later (mouth)
1.					
2.					
3.					

If you have had any test recently please could you bring the test results with you to your appointment. Please order a copy from you GP in plenty of time, if you have not kept one.

FAMILY HISTORY

What illnesses would you say ran in your family? _____

Please state major health problems of the following people.
If they are no longer alive please state the cause and age of death.

Father
Mother
Brothers (Include ages)
Sisters (include ages)
Children (include ages)

Paternal Grandfather
Paternal Grandmother
Aunts
Uncles

Maternal Grandfather
Maternal Grandmother
Aunts
Uncles

Please circle if any of your family have, or have had ...

Asthma	Diabetes	Epilepsy	Fatigue	Headaches	Blackouts or dizziness
Hay fever	Migraine	Obesity	Stomach disorders	Depression or Anxiety	
