QUESTIONNAIRE

First name: Last name:

DOB:

Email address:

Phone:

Street address:

Postcode:

Occupation:

Main presenting concern:

Secondary concern:

Current medications:

Known allergies:

We will discuss the below in depth in your appointment but please tick any of the below that relate to you or have in the past.

Medical history

Digestive:
☐ Bloating
☐ Nausea
☐ Flatulence
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Abdominal pain
☐ Irritable bowel syndrome
☐ Inflammatory bowel disease

Immune system:
☐ Frequent colds
☐ Reoccurring infections
☐ Herpes virus
☐ Glandular fever
☐ Autoimmune disease
☐ Urinary tract infections

Cardiovascular:
☐ Chest pain
☐ Shortness of breath on exertion
☐ Palpitations
☐ Easy bruising
☐ Swelling

Nervous system:
☐ Poor sleep
☐ Insomnia
☐ Dizziness
☐ Headaches
☐ Migraines

Mood:
☐ Depression
☐ Anxiety
☐ Panic attacks
☐ Mood disorder

Skin:
☐ Eczema
☐ Acne
☐ Rash
☐ Psoriasis

Female reproductive:
☐ PMS
☐ Spotting
☐ Irregular period
☐ Absent period

Musculoskeletal:
☐ Back problems
☐ Joint pain
☐ Stiffness in joints

Other:
☐ Asthma
☐ Diabetes
☐ Hayfever
☐ Anemia
☐ High blood pressure
☐ Low blood pressure
☐ High cholesterol