
A MEMBER OF YOUR FAMILY HAS HAD: (say who e.g. grandfather, aunt etc.)

Heart trouble

Parkinson's Disease

High Blood Pressure

Liver disorder

Arthritis (+ where)

Diabetes(+ age diagnosed.)

Cancer (+ where)

Other _____

YOU HAVE RECEIVED THE FOLLOWING DIAGNOSIS AND/OR YOUR PRESENT CHIEF COMPLAINT(S) IS:

If diagnosed, then by whom:

ARE YOU PRESENTLY UNDER TREATMENT? IF SO, FOR WHAT PURPOSE AND BY WHOM?

GENERAL:

Type of glasses you wear

Your hearing is

Name any foods, medicines and/or other substances that you are allergic to presently:

How was this allergy identified?

How would you describe your appetite?

Do you have a heavy feeling after eating?

Is there any bloating?

Do you emit gas at times?

How often do you have a bowel movement (BM)?

Do you ever experience diarrhoea? If so, how often

Are you ever constipated?

How many colds per year do you have?

Do you have any respiratory trouble(s)?

Do you suffer from sinusitis?

Do you enjoy your work?

Can you take a rest period at work?

I am somewhat: nervous _____ irritable _____ depressed
_____ stressed _____

I am worried about: _____

Do you have difficulty in going to sleep at night?

How often do you get up during the night?

I arise at _____ and retire at _____

Do you have bad breath?

Do you spit up a lot of mucous, especially in the morning?

Do you tire easily during the day?

If you are a woman, do you menstruate regularly or what is your cycle like?

How long do you menstruate for?

Describe your menstrual flow (heavy, scant, other):

Describe any discomfort(s) during or before a period:

What type of contraception do you use, if any?

Do you suffer from any discharge or thrush?

Do you sometimes observe swelling:

in your eyelids _____ fingers _____

ankles _____ other places:

Are you a social person and do you enjoy being with other people?

Do you have any hobbies/interests that you are pursuing at the moment?

Do you smoke? No / Never / Yes, at present _____ or stopped _____
years/months ago_____

If yes, how many do you or did you smoke per day?
cigarettes_____cigars_____ other _____

and for how many years did you or have you smoked for?

If you smoke at present, have you ever tried to give up smoking?

WHAT EXERCISES ARE YOU DOING, (IF ANY)

HOW OFTEN DO YOU GET INTO THE SUN?

PREVIOUS AND PRESENT DIET

Please state exactly what you eat and drink. Give specific details like lettuce, cucumber, tomato (not just salad) or Kraft Italian Dressing (not just salad dressing) or Diet Sprite, Tab, Coke (not just coldrink) or white commercial bread (not just bread) etc. Please also state the times that you eat and include sweets/snacks etc.

For how long did you follow;

previous diet _____ present diet _____

Wake up: time: _____

Previous:

Present:

Breakfast: time: _____

Previous:

Present:

Mid-morning: time: _____

Previous:

Present:

Lunch: time: _____

Previous:

Present

Mid-afternoon: time: _____

Previous:

Present:

Supper: time: _____

Previous:

Present:

After supper: time: _____

Previous:

Present:

If you use any condiments e.g. seasonings etc., please list them.

If you use any frozen, tinned and/or packaged foods, please list them.

How much tea and/or coffee do you consume?

Previously - tea _____ coffee _____

Presently - tea _____ coffee _____

How much alcohol do you consume? (stipulate beer, brandy etc.)

Is there any other information that you feel we should know?
