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|  | **NEW CLIENT FORM**  **Private & Confidential** | |
| Today’s Date: 19/08/2012 | | Client Ref (Office Use Only): |
| **CLIENT INFORMATION** | | |
| Last Name: | First Name(s): | |
| Date of Birth: | | Age: |
| Marital status: Married ☐ ; Single ☐ ; Living with Partner ☐ ; Separated ☐ ; Widowed ☐ ; Other ☐ | | |
| Address 1: | Address 2: | |
| City: | Post Code: | |
| Email Address: | | |
| Home Phone No.: (      ) | Mobile Phone No.: | |
| Please state how you would prefer to be contacted: | | |
| Referred by: GP ☐ ; Website ☐ ; Friend/Family Member ☐ ; Other ☐ please state | | |
| **Doctor’s Name**: | | |
| Address 1: | Address 2: | |
| City: | Post Code: | |
| Telephone No.: (      ) | | |

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| **FAMILY** | **WORK** |
| Do You Have Children? YES ☐ NO ☐ | What Is Your Occupation? |
| If Yes; Please State Age and Sex: | Do You Enjoy Work? YES ☐ NO ☐ |
| Do The Children Live With You? YES ☐ NO ☐ | How Many Hours Do You Work Each Week? |
| Do You Have Other Children Living With You?  YES ☐ NO ☐ | Do You Work Nightshifts? YES ☐ NO ☐ |
| If Yes; Please State Relationship: Step Children ☐ Foster Children ☐  Other ☐ (Please State) | |

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| **LIFESTYLE** | |
| Have You Ever Smoked? YES ☐ NO ☐ | If Yes; What Age Did You Start Smoking? |
| Do You Still Smoke? YES ☐ NO ☐ | If Yes; How Many Cigarettes Do You Smoke Each Day? |
| If No; When Did You Stop Smoking? |
| Do You Drink Alcohol? YES ☐ NO ☐ | If Yes; How Many Days In An Average Week Do You Drink? |
| How Many Drinks Do You Have On Each Day? |
| What Is Your Favourite Drink? |
| What Time Of Day Do You Usually Drink? |
| Do You Take/Ever Taken Recreational Drugs?  YES ☐ NO ☐ | If Yes; Which Drugs Have You Taken? |
|  | When Was The Last Time You Took These Drugs? |
| Do You Exercise? YES ☐ NO ☐ | If Yes; How Many Times Each Week? |
| On Average How Long Do You Exercise For? |
| What Type of Exercise Do You Do? |
| Where Do You Exercise? At The Gym ☐ ; Home ☐ ; Other ☐ (Please State) |

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| **LIFESTYLE (Continued)** | |
| What Do You Enjoy In Life? | |
| How Do You Relax? | |
| What Are Your Hobbies? | |
| How Would You Describe Your Home Life?  (Please tick all that apply) | Stressed ☐ ; Happy ☐ ; Unhappy ☐ ; Busy ☐ ;  Relaxed ☐ ; Easy ☐ . |
| Do You Spend the Majority of Your Time & Money to fulfil Responsibilities & Obligations? YES ☐ NO ☐ | |
| Do You Feel You Have An Excessive Amount of Stress in Your Life? YES ☐ NO ☐ | Do You Feel You Can Easily Handle the Stress in Your Life? YES ☐ NO ☐ |
| Daily Stressors: Please rate on a Scale of 1 to 10 (1 = Low; 10 = High)  Work Family Social Finances Health Other | |
| Do You Practice Meditation or Relaxation Techniques? YES ☐ NO ☐ How Often? | Please Check ALL that Apply:  Yoga ☐ ; Meditation ☐ ; Breathing Techniques ☐ ; Tai Chi ☐ ; Prayer ☐ ; Other ☐ |
| What is the average number of hours you sleep per night? >10 ☐ ; 8-10 ☐ ; 6-8 ☐ ; <6 ☐ | Do you have trouble falling asleep? YES ☐ NO ☐ |
| Do you wake up feeling refreshed? YES ☐ NO ☐ | Do you have problems staying asleep? YES ☐ NO ☐  What wakes you? |
| Do you snore? YES ☐ NO ☐ | Do you use sleeping aids? YES ☐ NO ☐  (If YES Please Explain) |
| What emotional support can you draw on? Spouse ☐ ; Family☐ ; Friends ☐ ; Religious/Spiritual ☐ ;  Pets ☐ ; Other ☐ (Please Explain) | |
| Do you have a history of significant exposure either at home or in the work place to any of the following?    Chemicals/Solvents ☐ ; Electromagnetic Radiation ☐ ; Heavy Metals ☐ ; Herbicides ☐ ; Pesticides/Insecticides ☐ ; Mould ☐ ; Other ☐ (Please Explain) | |

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| **MEDICAL CONCERN(S)** |
| Please give details of why you have chosen to make an appointment, giving as much information as you can.  Include, When and how your concerns started, any pain, type of pain (is it an ache, or is it sharp, does it come and go, or is it constant). Where and how often do symptoms/pain occur, do you know what alleviates or what aggravates the problem, have you had any previous treatments – what where they? |

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| **FAMILY HISTORY** | | | | | | | | | | | | |
| Please check the box(es) for all that apply for Blood Relatives only | **Mother** | **Father** | **Brother(s)** | **Sister(s)** | **Children** | **Maternal Grandmother** | **Maternal Grandfather** | **Paternal Grandmother** | **Paternal Grandfather** | **Aunts** | **Uncles** | **Others** |
| Age (if still alive) |  |  |  |  |  |  |  |  |  |  |  |  |
| Aged at Death (if deceased) |  |  |  |  |  |  |  |  |  |  |  |  |
| Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☒ | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Arthritis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Cancer | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Epilepsy | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| High Blood Pressure | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Kidney Disease | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Mental Illness | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Tuberculosis | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Other: | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **IMMUNISATIONS**  **(Please Check ALL You Have Had)** | | | | | |
| ☐ | Diphtheria, Tetanus, Pertussis (DTP) | | ☐ | Mumps | |
| ☐ | Measles | | ☐ | Rubella | |
| ☐ | Hepatitis A | | ☐ | Hepatitis B | |
| ☐ | Influenza | | ☐ | Tuberculosis | |
| ☐ | Human Papillomavirus (HPV) | | ☐ | Tetanus | |
| ☐ | Polio | | ☐ | Pneumococcal Conjugate Vaccine (PCV) | |
| ☐ | Meningitis C | | ☐ | Other (please specify) | |
| **CHILDHOOD ILLNESSES/DISEASES**  **(Please Check ALL You Have Had)** | | | | | |
| ☐ | Chicken Pox | | ☐ | Croup | |
| ☐ | German Measles | | ☐ | Measles | |
| ☐ | Meningitis | | ☐ | Scarlet Fever | |
| ☐ | Tonsillitis | | ☐ | Whooping Cough | |
| **ACCIDENTS/OPERATIONS/HOSPITALISATION**  **(Check Box if YES and Provide Date)** | | | | | |
| ☐ | | Head Injury | ☐ | | Neck Injury |
| ☐ | | Back Injury | ☐ | | Broken Bones |
| ☐ | | Other | | | |
| ☐ | | Appendectomy | ☐ | | Hysterectomy +/- Ovaries |
| ☐ | | Gall Bladder | ☐ | | Hernia |
| ☐ | | Tonsillectomy | ☐ | | Other |
| ☐ | | Other | ☐ | | No Operations |

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| **PREVENTIVE TESTS & DATE OF LAST TEST**  **(Check Box if YES and Provide Date)** | | | |
| ☐ | Full Physical Examination | ☐ | MRI Scan |
| ☐ | Bone Density | ☐ | CT Scan |
| ☐ | EBT Heart Scan (Ultrafast CT Scan) | ☐ | Upper Endoscopy |
| ☐ | ECG (Electrocardiogram) | ☐ | Upper GI Series  (Barium Meal & x-rays) |
| ☐ | Colonoscopy | ☐ | Ultrasound |
| ☐ | Stool Test (for Hidden Blood known as Occult Haemoglobin) | ☐ | Other |
| **DENTAL HISTORY**  **(Check Box if YES)** | | | |
| ☐ | Silver Mercury Filings (How Many) | ☐ | Tooth Pain |
| ☐ | Gold Filings | ☐ | Bleeding Gums |
| ☐ | Root Canal Filings | ☐ | Gingivitis |
| ☐ | Implants | ☐ | Problems with Chewing |
| ☐ | Floss Regularly | ☐ |  |

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| **MEDICATION** | | | | |
| **Current Medication** | | | | |
| **Medication** | **Dose** | **Frequency** | **Start Date** | **Reason for Use** |
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| **MEDICATION (Continued)** | | | | |
| **Previous Medication (Last 10 Years)** | | | | |
| **Medication** | **Dose** | **Frequency** | **Start Date** | **Reason for Use** |
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| **NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/MINERALS/HERBS/HOMEOPATHY )** | | | | |
| **Supplement/Brand** | **Dose** | **Frequency** | **Start Date** | **Reason for Use** |
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| Have your Medication/Supplements ever caused side effects/problems? | | | ☐ YES ☐ NO | How? |
| Have you had prolonged or regular use of NSAIDS? (non-steroidal anti-inflammatory drugs) | | | ☐ YES ☐ NO | e.g. Aspirin; Paracetamol; Ibuprofen |
| Have you had prolonged or regular use of Acid Blocking Drugs? | | | ☐ YES ☐ NO | e.g. Cimetidine |
| Have you had prolonged or regular use of Antacids? (Over counter drugs) | | | ☐ YES ☐ NO | e.g. Rennies; Tums; Milk of Magnesia |
| Frequent antibiotics? (>3 times/year) | | | ☐ YES ☐ NO |  |
| Long Term Antibiotics? | | | ☐ YES ☐ NO |  |
| Use of Steroids? | | | ☐ YES ☐ NO | e.g. Prednisone; inhalers |

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| **OTHER MEDICAL INFORMATION** | |
| Do you suffer from headaches/migraines? YES ☐ NO ☐ How often? | |
| Do you know what triggers them? YES ☐ NO ☐ Please state trigger source? | |
| Do you get any visual disturbances? YES ☐ NO ☐ What are they & how often? | |
| Do you know what triggers them? YES ☐ NO ☐ Please state trigger source? | |
| Do you suffer from dizziness? YES ☐ NO ☐ | Do you suffer from vertigo? YES ☐ NO ☐ |
| Do you feel any weakness? YES ☐ NO ☐ | Do you suffer from fainting or fits? YES ☐ NO ☐ |
| Do you suffer from dizziness? YES ☐ NO ☐ | Do you suffer from vertigo? YES ☐ NO ☐ |
| Please rate your energy levels (1 = low & 10 = high) | 1 ☐ ; 2 ☐ ; 3 ☐ ; 4 ☐ ; 5 ☐ ;  6 ☐; 7 ☐ ; 8 ☐; 9 ☐; 10 ☐ |
| Please rate your stress levels (1 = low & 10 = high) | 1 ☐ ; 2 ☐ ; 3 ☐ ; 4 ☐ ; 5 ☐ ;  6 ☐; 7 ☐ ; 8 ☐; 9 ☐; 10 ☐ |
| Please rate your memory (1 = low & 10 = high) | 1 ☐ ; 2 ☐ ; 3 ☐ ; 4 ☐ ; 5 ☐ ;  6 ☐; 7 ☐ ; 8 ☐; 9 ☐; 10 ☐ |
| Please rate your ability to concentrate (1 = low & 10 = high) | 1 ☐ ; 2 ☐ ; 3 ☐ ; 4 ☐ ; 5 ☐ ;  6 ☐; 7 ☐ ; 8 ☐; 9 ☐; 10 ☐ |
| Please rate your general mood (1 = low & 10 = high) | 1 ☐ ; 2 ☐ ; 3 ☐ ; 4 ☐ ; 5 ☐ ;  6 ☐; 7 ☐ ; 8 ☐; 9 ☐; 10 ☐ |
| Do you suffer from flatulence? YES ☐ NO ☐ | Do you suffer any bloating? YES ☐ NO ☐ |
| Do you suffer from abdominal pain? YES ☐ NO ☐ | Do you suffer from indigestion? YES ☐ NO ☐ |

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| **OTHER MEDICAL INFORMATION (continued)** | |
| Do you suffer from reflux/burping? YES ☐ NO ☐ | Do you suffer any acidity? YES ☐ NO ☐ |
| Do you suffer from nausea/vomiting? YES ☐ NO ☐ | How many times a day do you produce a stool? |
| Do you suffer pain when passing a stool? YES ☐ NO ☐ | Is there blood in your stool? YES ☐ NO ☐ |
| Do you suffer from constipation? YES ☐ NO ☐ | Do you suffer from diarrhoea? YES ☐ NO ☐ |
| Do you suffer from rectal bleeding? YES ☐ NO ☐ | Do you suffer from haemorrhoids? YES ☐ NO ☐ |
| Have you had any weight change recently? YES ☐ NO ☐ | How many colds do you get in a year? |
| How long do the colds last for? | Do you suffer from earache? YES ☐ NO ☐ |
| Do you suffer from hearing loss? YES ☐ NO ☐ | Do you suffer from catarrh? YES ☐ NO ☐ |
| Do you suffer from sore throats? YES ☐ NO ☐ If YES how often? | |
| Do you suffer from coughs? YES ☐ NO ☐ If YES how often?       Is it Productive? YES ☐ NO ☐ | |
| Do you suffer from wheezing or difficulty breathing? YES ☐ NO ☐ If YES how often?  Is there a trigger? YES ☐ NO ☐ If YES what it is? | |
| How many times a day do you urinate? | Do you suffer pain or burning on urination?  YES ☐ NO ☐ |
| Do you suffer any difficulty in starting to urinate?  YES ☐ NO ☐ | Do you suffer chest pains? YES ☐ NO ☐ |
| Do you suffer from palpitations? YES ☐ NO ☐ | Do you suffer with varicose veins? YES ☐ NO ☐ |
| Do you suffer from cold hands, feet or nose? YES ☐ NO ☐ | |
| Do you suffer joint pain or stiffness? YES ☐ NO ☐ If YES where?  Do you know what causes this? YES ☐ NO ☐ If YES what it is? | |
| Do you suffer spasms or cramps? YES ☐ NO ☐ If YES where?  How often does this happen? | |
| How would you describe your skin? (Tick ALL that apply) Oily ☐ Dry ☐ Combination ☐ Acne ☐ | |

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| **OTHER MEDICAL INFORMATION (continued)** | |
| Do you suffer with eczema? YES ☐ NO ☐ If YES where? | |
| Do you suffer with psoriasis? YES ☐ NO ☐ If YES where? | |
| Do you suffer with any rashes? YES ☐ NO ☐ If YES where? | |
| Do you suffer with Athletes Foot? YES ☐ NO ☐ | |
| Do you suffer from thrush? YES ☐ NO ☐ If YES, is this a recurring problem YES ☐ NO ☐  If YES How often does it reoccur | |
| Do you have an aversion to cold? YES ☐ NO ☐ | Do you have an aversion to heat? YES ☐ NO ☐ |
| Do you suffer with loss or growth of body hair? YES ☐ NO ☐ | |

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| **GYNAECOLOGICAL HISTORY (Women Only)**  **(Check Box if YES and Provide Number)** | | | | | |
| ☐ | | Pregnancies | ☐ | | Miscarriage |
| ☐ | | Normal Delivery | ☐ | | Caesarean Section |
| ☐ | | Abortion | ☐ | | Living Children |
| ☐ | | Post Natal Depression | ☐ | | Toxaemia |
| ☐ | | Gestational Diabetes | ☐ | | Baby Over 8 Pounds |
| ☐ | | Breast Feeding (For How Long) | ☐ | | None |
| **MENSTRUAL HISTORY** | | | | | |
| **YES** | **NO** |  | **YES** | **NO** |  |
|  |  | Age at First Period |  |  | Frequency of Period |
|  |  | Length of Period | ☐ | ☐ | Pain |
| ☐ | ☐ | Clotting | ☐ | ☐ | Has Your Period Ever Skipped  (For How Long?) |
|  |  | Last Menstrual Period | ☐ | ☐ | Do You Use Contraception? |
| ☐ | ☐ | The ‘Pill’ | ☐ | ☐ | Condom |
| ☐ | ☐ | Diaphragm | ☐ | ☐ | IUD (Inter Uterine Devise) |
| ☐ | ☐ | Partner Vasectomy |  |  |  |
| **WOMEN’S DISORDERS/HORMONAL IMBALANCES**  **(Check Box if YES)** | | | | | |
| ☐ | | Fibrocystic Breasts | ☐ | | Endometriosis |
| ☐ | | Fibroids | ☐ | | Infertility |
| ☐ | | Painful Periods | ☐ | | Heavy Periods |
| ☐ | | PMT (Pre Menstrual Tension) | ☐ | | Mammogram (Date of Last Test) |
| ☐ | | Breast Biopsy (Date of Biopsy) | ☐ | | PAP Test (Date of Cervical Smear)  Normal ☐ ; Abnormal ☐ |
| ☐ | | Bone Density (Date)       Low ☐ ; High ☐ ; Normal Range ☐ | | | |
| ☐ | | Are You In the Menopause? | | | |
| ☐ | | Mood Swings | ☐ | | Hot Flushes |
| ☐ | | Vaginal Dryness | ☐ | | Concentration/Memory Problems |
| ☐ | | Heavy Bleeding | ☐ | | Decreased Libido |
| ☐ | | Headaches | ☐ | | Joint Pains |
| ☐ | | Loss of Control of Urine | ☐ | | Weight Gain |
| ☐ | | Use of Hormone Replacement Therapy  (For How long) | ☐ | | Palpitations |

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| **MEN’S HISTORY**  **(Check Box if YES)** | | | |
| ☐ | PSA Test (Prostate Specific Antigen) Date |  | PSA Level: ☐ 0-2; ☐ 2-4;  ☐ 4-10; ☐ >10 |
| ☐ | Prostate Enlargement | ☐ | Prostate Infection |
| ☐ | Change in Libido | ☐ | Impotence |
| ☐ | Difficulty Obtaining an Erection | ☐ | Difficulty Maintaining an Erection |
| ☐ | Urination during the Night  (How Many Times) | ☐ | Urgency/Hesitancy/Change in Urinary Stream |
| ☐ | Loss of Control of Urine |  |  |

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| **DIET** | | | | | | |
| Have you ever has a Nutrition Consultation? | | ☐ YES ☐ NO | | | Jan 2000 | |
| Have you made any changes to your eating habits because of your health? | | ☐ YES ☐ NO | | | How? | |
| Do you currently follow a special diet or nutritional program? | | ☐ YES ☐ NO | | | Low Fat ☐ ; Low Carbohydrate ☐ ; High Protein ☐ ;  Low Sodium ☐ ; Diabetic ☐ ; Dairy Free ☐ ;  Wheat Free ☐ ; Gluten Restricted ☐ ; Vegetarian ☐ ;  Vegan ☐ ;  Program specific for Weight Loss /Maintenance ☐ | |
| Current Weight: | Desired Weight +/- 5lbs | | | | | Lowest Adult Weight |
| How often do you weigh yourself? | Daily ☐ ; Weekly ☐ ; Monthly ☐ ; Rarely ☐ ; Never ☐ | | | | | |
| How would you rate your appetite?  (1 = low/10 = high) | 1 ☐; 2 ☐; 3 ☐; 4 ☐; 5 ☐; 6 ☐; 7 ☐; 8 ☐; 9 ☐ ; 10 ☐ | | | | | |
| Do you enjoy food? | ☐ YES ☐ NO | | | What % of your diet is organic? | | |
| Do you avoid any particular foods? | ☐ YES ☐ NO | | | Please state which Food and Why: | | |
| Do you have cravings for any foods? | ☐ YES ☐ NO | | | Please state which Food: | | |
| What are your favourite foods? | | | | | | |
| Do you do the food shopping? | ☐ YES ☐ NO | | | If NO, who does? | | |
| Do you read the food labels? | ☐ YES ☐ NO | | |  | | |
| Do you do the cooking? | ☐ YES ☐ NO | | | If NO, who does? | | |
| How many meals do you eat out each week/month? | 0-1 ☐ ; 1-3 ☐ ; 3-5 ☐ ; >5 ☐ per week ; Once a Month ☐ ;  Twice a Month ☐ ; Never ☐ | | | | | |
| Do you avoid any particular foods? | ☐ YES ☐ NO | | | Please state which Food and the Reason: | | |
| What drinks/foods would you find it hard to ‘give up’? | | | | | | |
| How many cups of tea do you drink in a day? | | | How many cups of coffee do you drink in a day? | | | |
| Do you add sugar to your drinks? | ☐ YES ☐ NO | | | How many? | | |
| How many glasses of water do you drink in a day? | | | | | | |
| How many times a day do you:  Eat at your desk or on the run?       ; Skip a meal?       ; Eat a freshly cooked meal? | | | | | | |

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| **DIET (Continued)** | | |
| Do you add salt to your food? | ☐ YES ☐ NO | ☐ When cooking ☐ At the table |
| Please Tick **ALL** items you would have on a weekly basis:  White Bread ☐; Brown Bread ☐; White Pasta ☐; Wholegrain Pasta ☐; White Rice ☐ ;  Wholegrain Rice ☐; Fizzy Drinks ☐; Coffee ☐; Filtered Water ☐; Alcohol ☐;  Cake/Biscuits ☐ ; Fried Food ☐; Fast-food/Take-away☐; Deli Meats ☐; Chocolate/Sweets ☐; Sweeteners ☐ ; Butter ☐; Vegetable/Low fat Spread ☐; Fresh Vegetables ☐; Fresh Fruit ☐ | | |

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| **IN ORDER TO IMPROVE YOUR HEALTH HOW WILLING ARE YOU?**  **(On a Scale of 5 (Very Willing) to 1 (Not Willing))** | |
| Significantly modify your diet? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Take Nutritional Supplements each day? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Keep a Record of everything you eat each day? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Modify your Lifestyle? (e.g. work demands; sleep patterns) | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Practice a relaxation technique? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Engage in regular exercise? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Have periodic Laboratory tests to assess progress? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Comments: | |
| At the present time, how supportive do you think the people in your household will be to you implementing the above changes? | 5 ☐; 4 ☐; 3 ☐; 2 ☐; 1 ☐ |
| Comments: | |

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| **OTHER INFORMATION & DECLARATION** |
| **Other Information** |
| Please supply any additional information that you feel will be useful during your consultation: |
| **Declaration** |
| **I declare that the information provided is correct to the best of my knowledge.**  **Signature: Date:** |