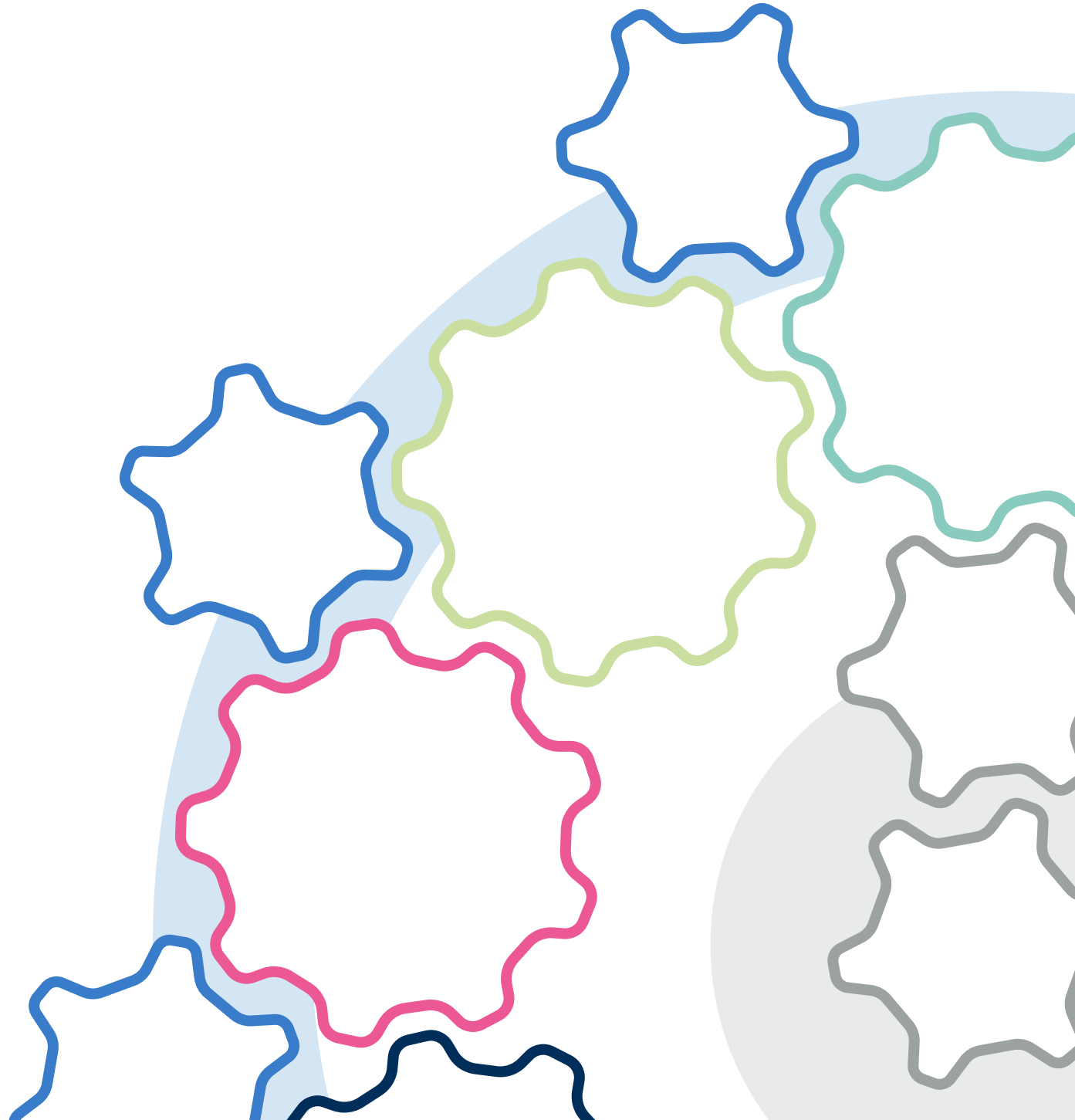
ADAPTIVE HEALTH

Client Questionnaire



Personal Details

Full name		**Date of birth**		**Age**	
Email		**Telephone** (home/mobile)		**Gender**	
Address (including postcode)					

Weight (Kg, Stone, lbs)		**Height** (Feet/inches, metres/cm)	
Blood Pressure (if known)		**Blood type** (if known)	
GP name			
GP address (surgery details)			
Permission	Do you give permission for your practitioner to contact your GP if need be? **YES** ☐ **NO** ☐		

Other practitioners
Please detail any other types of practitioners you have visited e.g. reflexologist, chiropractor, herbalist.

Employment status (Employed, unemployed, retired etc.)		**Job description**	
Marital status (Single, married, divorced, widow/widower etc.)		**Number of children** (if any)	

Current health concerns in order of priority
Please detail below the main health conditions or symptoms which you would like support and advice on.
Please also detail if you are currently undergoing any form of medical investigation e.g. scans/blood tests.

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Please tick if you have experienced any of the below symptoms:

Persistent or regular pain in any of the following locations -

Head ☐	Temples ☐	Eyes ☐
Abdomen ☐	Chest ☐	On passing urine ☐

Blood in any of the following -

Sputum ☐	Vomit ☐
Urine ☐	Stools ☐

Recent changes in any of the following -

Mood (e.g. negative thoughts) ☐	Thirst ☐	Urination ☐
Bowel habits ☐	Skin/pallor ☐	Vision ☐
Breathing ☐	Weight ☐	Appetite ☐
Body/face shape ☐	Swallowing ☐	Non-menstrual vaginal bleeding ☐

Please provide further detail of any ticked:

Current medication
Please give full details of any prescribed, or over the counter medication you are taking.
If you are taking 1 medication multiple times during the day, please detail – for example 5mg in the morning and 5mg in the evening.

Name	Dose per day	Reason for taking	Duration

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Previous medication
Please give full details of any medication previously taken, which you are now no longer taking. Please include the full name, how long you were taking it for, and when you ceased taking the medication.

Current supplements
Please give full details of any supplements you are taking, including any herbs.

Name (including brand)	**Dose per day**	**Reason for taking**	**Duration**

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Adaptive Health Client Questionnaire

Please tick which of the following statements apply to you. You don't have to agree with every part of each statement, but even if *some* part applies to you, you can tick it anyway. Please also underline or circle which specific aspect of the statement applies to you.

Name: ..... Date:.....

Nervous					
Thinking (Cognitive/Sensorimotor)	**Please Tick**	**Stress (Wired) 'Hyper-arousal'**	**Please Tick**	**Stress (Low Energy/Mood) 'Hypo-arousal'**	**Please Tick**
I am very forgetful, have difficulties with concentrating, reading, writing, listening, planning, or thinking. I feel fuzzy headed, like I can't think straight ('brain fog').		Sometimes I can be quite wired or hyperactive, especially later in the day.		I feel tired, especially in the morning.	
People say my personality has changed.		I get stressed, anxious, irritable, or even angry, easily.		I sometimes feel quite low – depressed or unmotivated.	
I don't have much of a social life or I'm less interested in people or activities I used to enjoy.		I have difficulty sleeping – either falling asleep, staying asleep, or even insomnia. I sometimes or often use alcohol or sedatives to relax or sleep.		I drink coffee, take stimulants, or exercise to boost my energy.	
I have sensory issues – poor hearing, numbness, vision problems (blurring or greying patches not due to ageing).		I don't get outdoors much, spend a lot of time indoors under artificial light/ look at TVs or screens a lot, especially in the evening.		I take drugs or medication to support my mood (e.g. anti-depressants).	
I'm clumsy, dropping things or bumping into things regularly.		I am a bit of a perfectionist, addictive about things, or even obsessive compulsive.		I'm overweight, especially around my middle.	
I eat foods containing MSG (monosodium glutamate) e.g. Chinese food, or foods containing aspartame (artificial sweetener) such as processed food and fizzy drinks, yoghurts etc.		I feel like I'm under a lot of stress and/or have experienced significant emotional trauma in my life (e.g. during childhood).		I crave salty or spicy foods.	
Test from a doctor or practitioner show one/some of: brain shrinkage, strokes/mini strokes, low dopamine, high homocysteine. Genetic tests may show *APOE*, *MTHFR*, or *PEMT* variants.		Test from a doctor or practitioner show one/some of: high cortisol (especially later in the day), low or irregular heart rate variability, low magnesium and B6. Genetic tests may show *MTHFR*, *COMT*, or *MAO* variants.		Test from a doctor or practitioner show one/some of: low cortisol/DHEA, vitamin B12, B6, folate, B5, C, magnesium, zinc. Genetic tests may show *MTHFR*, *COMT*, or *MAO* variants.	
Diagnosis or family history of one/some of: Alzheimer's, dementia, multiple sclerosis, motor neurone disease, Parkinson's, Huntington's, stroke/ TIA, autism, ADHD, learning difficulties, dyspraxia etc.		Diagnosis or family history of one/some of: OCD, hyperactivity, anxiety, manic depression, bipolar, insomnia, hyperthyroidism, PTSD etc.		Diagnosis or family history of: depression, chronic fatigue syndrome.	

Energy					
Blood Glucose (Fuelling)	**Please Tick**	**Cell Energy**	**Please Tick**	**Thyroid**	**Please Tick**
My energy can be quite up and down. It can slump after eating.		I get tired all the time, even during really simple daily activities.		I'm generally tired all the time.	
Sometimes I feel shaky, dizzy, or irritable, especially if I've skipped a meal.		I've had prolonged debilitating periods of fatigue e.g. time off work with severe exhaustion.		I'm overweight all over, not just around the middle.	
I crave and /or eat a lot of sugar or carbohydrates (rice, pasta, potatoes).		My muscles can get very heavy or even painful.		I have some/all of the following: thinning hair/ eyebrows, poor quality skin/hair/nails, weak voice, constipation, puffy skin/water retention, feel the cold a lot, goitre.	
I have to eat frequently and/or excessively to maintain my energy levels.		I don't recover well from exercise or physical stress.		I don't eat many iodine-containing foods – seafood, seaweed.	
My weight fluctuates, or I am overweight.		I have sensitivities to chemicals or some foods.		Test from a doctor or practitioner show one/some of: high TSH, low T4/T3, low body temperature e.g. Broda Barnes test, high thyroid antibodies, goitre.	
I get thirsty often and/or frequently wake up at night to urinate.		I had a breakdown, major trauma, severe infection in the past and I've never properly recovered.		Diagnosis or family history of one/some of: thyroid disease e.g. hypothyroidism, Hashimoto's disease, an autoimmune condition (e.g. lupus, rheumatoid arthritis).	
I don't exercise much and/or spend a lot of time sitting.		I have amalgam fillings, crowns, or have been exposed to heavy metals– e.g. aluminium, lead (e.g. workplace), eating tuna, or tinned foods.		**Hyperthyroid:** some/all of the following: fatigue, underweight, agitated, diarrhoea, tremors, palpitations, sweat a lot, have anxiety.	
Test from a doctor or practitioner show one/some of: high blood sugar levels, insulin, triglycerides, cholesterol, or HbA1c.		Test from a doctor or practitioner show one/some of: chronic infection, low magnesium, B12, folate, B1, B2, B3, iron, high heavy metals or toxic load.		**Hyperthyroid:** Test from a doctor or practitioner show one/some of: low TSH, high T4 and/or T3, high thyroid antibodies, goitre.	
Diagnosis or family history of one/some of: obesity/ borderline obesity, cardiovascular disease, metabolic syndrome, diabetes, PCOS.		Diagnosis or family history of one/some of: chronic fatigue syndrome, ME, fibromyalgia, severe infection (e.g. Epstein Barr, Lyme disease).		**Hyperthyroid:** Diagnosis or family history of one/ some of: hyperthyroidism, Grave's disease, another autoimmune condition.	

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Methylation	Please Tick
I have symptoms of low or variable mood and/or low motivation. I can be forgetful or have 'brain fog'.	
I don't eat much meat or dairy, or I am vegetarian or vegan, or I don't eat many vegetables.	
I am exposed to quite a lot of artificial chemicals – household chemicals, cosmetics, air pollution (city living or in the workplace).	
I have an inflammatory disease (e.g. arthritis, lupus).	
I take proton pump inhibitors (PPIs like omeprazole) for reflux, antacids for indigestion, or have had several courses of antibiotics.	
I have had problems with fertility or have had a miscarriage.	
I have symptoms of imbalanced hormones (e.g. fluctuating or heavy periods, PMS, fibroids, endometriosis).	
Diagnosis or family history of one/some of: depression, anxiety, Alzheimer's, dementia, cardiovascular disease, or other chronic, inflammatory disease.	
Test from a doctor or practitioner show one/some of: low vitamin B12 or folate, high homocysteine. Genetic tests may show *MTHFR*, *MTR* or *DHFR* variants.	

Detoxification			
General Detoxification (pathological)	Please Tick	Sulphation/Glucuronidation	Please Tick
I feel ill when exposed to chemicals (e.g. perfumes, cleaning products, exhaust fumes, cosmetics).		Red wine, dried fruits, processed meats (salami, sausages) make me feel unwell e.g. headaches, migraines, facial flushing, rash, wheezing.	
I live and/or work in a city (travel by bike, public transport or car).		I react to 'healthy foods' e.g. fruits/vegetables especially cruciferous/green vegetables or onions/ garlic/leeks e.g. as symptoms above.	
I don't buy organic food or use organic products.		I have jaundice, yellow whites of eyes or a diagnosis of Gilbert's syndrome (Glucuronidation).	
I don't/rarely eat cruciferous vegetables (e.g. broccoli, cauliflower).		I drink alcohol regularly.	
I'm frequently exposed to plastics (plastic containers in cooking/storage, cling film, use tinned foods, drink tap water).		I'm frequently exposed to plastics (plastic containers in cooking/storage, cling film, use tinned foods, drink tap water).	
I use recreational drugs, caffeine, alcohol, smoke, or am exposed to passive smoking.		I have symptoms of imbalanced hormones (e.g. fluctuating or heavy periods, PMS, fibroids, endometriosis).	
I have amalgam fillings, crowns, or have been exposed to heavy metals in the past – aluminium, lead (e.g. workplace), eating tuna, tinned foods.		I have frothy, smelly urine and/or eggy flatulence and/or bloating.	
I use multiple medications.		I use multiple medications, especially painkillers (e.g. codeine, paracetamol), anti-inflammatories (e.g. ibuprofen), asthma inhalers, benzodiazepines (e,g. diazepam), immunosuppressants, warfarin, roaccutane.	
Diagnosis or family history of one/some of liver or kidney disease.		Test from a doctor or practitioner show one/ some of: high beta-glucuronidase (stool test), high bilirubin, high oestrogen, high zonulin (leaky gut). Genetic tests may show *CBS*, *SULT*, or *SUOX* (sulphation), or *UGT* (glucuronidation), variants.	

Heart (Cardiovascular)							
Rhythm	Please Tick	Oxygenation	Please Tick	Lipid Balance	Please Tick	Circulation	
I get palpitations/fluttery feeling in my chest.		My skin is pale, I have pale eyelids and/or blue lips.		I have high cholesterol. I use statins/red yeast rice extract.		I have poor circulation e.g. cold hands and feet, erectile dysfunction.	
I feel dizzy/lightheaded on standing or have fainting episodes.		I snore, waking up tired or with brain fog.		I regularly eat high fat foods (meat, butter, deep fried foods) and/or high carb/sugar/fructose foods – potatoes, rice, pasta, fruit juices.		I have pain, cramping in lower legs, or restless legs.	
I eat processed foods (e.g. crisps, pre-made sauces), ready meals/ take-aways regularly.		I get a high heart rate when exercising and/or have shallow breathing/get short of breath easily.		I am overweight.		I get stressed, anxious, irritable or even angry easily.	
I drink alcohol or caffeinated drinks regularly.		I'm vegan/vegetarian or don't eat (much) red meat.		I drink alcohol regularly, smoke, or am exposed to passive smoking.		I have puffy skin, water retention, swollen ankles.	
I eat fewer than 5 portions of vegetables a day.		I don't exercise much and/or spend a lot of time sitting.		I don't digest fatty foods well and have pale/grey/fatty stools.		I suffer with easy bruising, spider veins, poor wound healing, prolonged bleeding after a cut/injury, DVT.	
I frequently add (plenty of) salt of salt to meals.		I have very heavy periods or other reason for blood loss recently e.g. injury, operation, childbirth, blood donor.		I rarely/never eat oily fish and/or eat a lot of processed food.		I feel dizzy/lightheaded on standin or have fainting episodes.	
Diagnosis or family history of one/ some of: atrial fibrillation, arrhythmia, cardiomyopathy, valve problems, myocarditis, endocarditis, pericarditis.		Diagnosis or family history of one/ some of: anaemia, pernicious anaemia, sleep apnoea, nasal polyps, haemochromatosis, lung disease, cystic fibrosis, sarcoidosis.		Diagnosis or family history of one/ some of: high cholesterol, heart disease, stroke, gall bladder disease/ stones/removal, fatty liver.		Diagnosis or family history of one/ some of: heart disease/failure, stroke, heart attack, angina, vertigo, Meniere's disease, varicose veins, Raynaud's syndrome, preeclampsia.	
Test from a doctor or practitioner show one/ some of: abnormal ECG and electrolytes, reduced kidney function, high creatine kinase.		Test from a doctor or practitioner show one/some of: low haemoglobin, ferritin, iron, folate, B12, low blood pressure, high fasting glucose upon waking.		Test from a doctor or practitioner show one/some of: high LDL/LDL:HDL ratio, triglycerides, high glucose/HbA1c, ESR/CRP.		Test from a doctor or practitioner show one/some of: high blood pressure (over 120/80), CRP/ESR, fibrinogen/ platelets, cholesterol.	

Structure					
Bone	Please Tick	Joint/Ligament/Tendon	Please Tick	Skin, Hair, Nails (Integumentary)	Please Tick
I have reduced height, stooped posture as I've got older, and/or slow growth or short stature during childhood/adolescence.		I have sore, stiff, or 'clicky' joints.		I have dull, wrinkled, inflamed skin, and/or brittle, dull, thinning, receding, or prematurely greying hair, and/ or poor quality, slow growing, or grooved nails.	
I'm over 50 and/or approaching or have gone through the menopause.		I've had/have ligament or joint injury through work, exercise, or sport.		My skin is easily bruised, or I have slow wound healing.	
I have a low calcium and/or vitamin D diet (dieting, fasting, vegan, dairy intolerant) or magnesium/other minerals (low intake of vegetables, nuts, seeds, pulses such as lentils).		I have loose joints e.g. very bendy fingers, double-jointed, sometimes slight dislocations (e.g. knees).		I used to/still smoke cigarettes.	
I work indoors, have low sunlight exposure on skin (live in a cold country, cover up, always use strong sunscreen etc.).		I'm an athlete or do a lot of sport, but can get sore, and perhaps don't give myself time to recover.		I eat a low zinc diet (animal products, shellfish, nuts, seeds).	
I don't exercise much on my feet and/or spend a lot of time sitting.		I don't eat much protein (meat, fish) or I have a vegetarian or vegan diet.		I sunbathe or use sunbeds a lot.	
I have a high caffeine, meat, sugar, alcohol, fizzy drink intake.		I work indoors, have low sunlight exposure on skin (live in a cold country, cover up, always use strong sunscreen etc.).		Regular use of topical synthetic products such as cosmetics or antibacterial products.	
Diagnosis or family history of one/some of: osteoporosis, osteopenia, brittle bones, fractures, eating disorder, scoliosis.		Diagnosis or family history of one/some of: ligament hypermobility (Ehler's Danlos), tendinitis, arthritis, gout, ankylosing spondylitis.		Diagnosis or family history of one/some of: dermatitis, psoriasis, eczema, acne, skin infections, vitiligo, skin cancer.	
Test from a doctor or practitioner show one/some of: low/abnormal bone density, low vitamin D or K, calcium, boron or magnesium, low oestrogen or testosterone.		Test from a doctor or practitioner show one/some of: low zinc, manganese, copper, vitamin C, and D, high CRP. Genetic tests may show *COL1A1* or *COL5A1* or *ACTN3* variants.		Test from a doctor or practitioner show one/some of: low oestrogen/testosterone, zinc, iron, copper, vitamin A, lysine, vitamin B12, C. Genetic tests may show *COL1A1* or *COL5A1* variants.	

Immune							
Low Immunity	Please Tick	Allergy	Please Tick	Inflammation	Please Tick	Autoimmunity	Please Tick
I'm often ill, picking up infections easily and/or finding it hard to shake them off (flu, cold sores etc.).		Diagnosis or family history of one/ some of: hay fever, rhinitis, eczema, dermatitis, urticaria (prickly heat), anaphylaxis, asthma.		Diagnosis or family history of one/ some of: chronic inflammatory conditions - e.g. psoriasis, rheumatoid arthritis, Inflammatory Bowel Disease, multiple sclerosis, periodontal or heart disease.		Diagnosis or family history of one/ some of: autoimmune condition e.g. psoriasis, rheumatoid arthritis, IBD, multiple sclerosis, coeliac.	
When I'm ill, I get swollen lymph nodes (e.g. lumps in neck, under arms) or tonsils.		I am very sensitive to 'allergens' e.g. cat dander, dust mites, pollen.		I am recovering slowly from an operation, infection, or injury.		I have food sensitivities/allergies. I 'react' to many foods (e.g. skin rashes, headaches), so my diet is quite restricted.	
I have been prescribed antibiotics multiple times and/or have taken/ take immunosuppressants.		I frequently take anti-histamines and antibiotics to manage my symptoms.		I've used steroids for a long time.		I rarely/never eat oily fish and/or eat a lot of processed food.	
I work indoors, have low sunlight exposure on skin (live in a cold country, cover up, always use strong sunscreen etc.).		I'm a stickler for hygiene - regular user of antibacterial gels, wipes and bleach.		I rarely/never eat oily fish and/or eat a lot of processed food.		I get stressed, anxious, irritable, or even angry, easily.	
I visit/work in places where there are infections – e.g. hospitals, health centres, nurseries, schools.		I eat quite a lot of dairy, gluten-containing and sugary foods.		I am overweight.		I work indoors, have low sunlight exposure on skin (live in a cold country, cover up, always use strong sunscreen etc.).	
I had a severe infection such as pneumonia, chicken pox/shingles, glandular fever in the past.		I wasn't breast fed (or for long) as a baby and/or I was born by C-section.		I don't give myself enough time to relax or recover when ill or when I've exercised.		I have been prescribed antibiotics multiple times.	
Test from doctor/practitioner show one/some of: low vitamin D, C, zinc, B12, folate, iron, white blood cells, IgA, chronic infections such as Lyme's disease, Epstein Barr (EBV).		Test from doctor/practitioner show one/some of: low vitamin D and omega-3, contact sensitivity, high IgE or high histamine. Genetic tests show *MTHFR*, *DAO*, *HNMT, NAT2, MAO-B* variants.		Test from doctor/practitioner show one/some of: low vitamin D, low essential fatty acids, high white blood cell count, high CRP/ESR, high histamine, high homocysteine. Gene tests show *IL-6*, *TNF-a*, *HLA* variants.		Test from doctor/practitioner show one/some of: low vitamin D, low omega-3, high CRP, ESR, histamine, homocysteine, or specific antibodies (e.g. rheumatoid factor, ANA). Genetic tests show *IL-6*, *TNF-a*, *HLA* variants.	

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Digestion

Digestion/Absorption	Please Tick	Motility	Please Tick	Integrity	Please Tick	Gut Bacteria	Please Tick
I see undigested foods in my stool and/or have pale, grey, fatty stools.		I get painful indigestion.		I have food sensitivities/allergies. I 'react' to many foods (e.g. skin rashes, diarrhoea, headaches), so my diet is quite restricted .		I suffer with anal itching, thrush, and regular fungal infections such as Athlete's foot.	
I get indigestion, bloating, flatulence, burping, or coughing after meals.		My bowel habits can be irregular with constipation, diarrhoea, or a mixture.		I have a diet that includes a lot of dairy, grains (gluten), pulses (lectins), and sugar.		I have bloating, flatulence, and abdominal pain after eating, especially high carbohydrate or sugar foods.	
I get reflux, a burning sensation in my throat, and/or cough a lot during/after eating or in bed.		I sometimes/frequently feel the urgency to 'go' to the toilet to pass a bowel movement.		I regularly use multiple medications, especially non-steroidal anti-inflammatories such as ibuprofen.		My digestive trouble started after a trip abroad or an episode of food poisoning.	
I have very limited time to eat. I often skip meals, snack, eat quickly on the go, and don't relax after eating.		I feel sick, bloated, or overfull for a long time after eating.		I have taken several courses of antibiotics in the past.		I have taken several courses of antibiotics in the past.	
I take proton pump inhibitors (PPIs like omeprazole) for reflux, antacids for indigestion.		I am/have been very stressed with possible anxiety or depression.		I have chronic/frequent constipation or diarrhoea.		I wasn't breast fed (or for long) as a baby and/or I was born by C-section.	
I've lost weight, or have difficulty maintaining weight.		I take medications for my mood or to calm me down e.g. SSRIs.		I've lost weight, or have difficulty maintaining weight.		I don't eat a lot of fibre rich foods.	
Diagnosis or family history of one/some of: IBS, lactose intolerance, reflux (GERD) gastritis, heartburn, ulcers, hiatus hernia, gall bladder disease, gallstones, gall bladder removal, coeliac, IBD, hyperthyroid, pancreatitis.		Diagnosis or family history of one/some of: IBS, IBD, constipation, incontinence, diarrhoea, diverticulitis.		Diagnosis or family history of one/some of: coeliac, IBD, gastritis, diverticulitis, food sensitivities, gut surgery/ resection, autoimmunity, liver disease.		Diagnosis or family history of one/some of: IBS, diarrhoea, food poisoning, parasitic infection, or IBD.	
Test from doctor/practitioner show one/some of: low stomach acid, *H. pylori* infection, low enzymes and bile production, high faecal fats, food allergies or intolerances, nutrient deficiencies e.g. B12, iron.		Test from doctor/practitioner show one/some of: imbalance of gut microbiome, leaky gut.		Test from doctor/practitioner show one/some of: *H. pylori*, imbalance of gut microbiome, leaky gut (e.g. high zonulin, faecal secretory IgA, lactoferrin, EPX, calprotectin).		Test from doctor/practitioner show one/some of: imbalanced gut bacteria including SIBO, parasites or fungal overgrowth, low secretory IgA. Genetic tests may show *FUT2* variants.	

Sex Hormones

High Oestrogen	Please Tick	Low Oestrogen	Please Tick	High Testosterone	Please Tick	Low Testosterone	Please Tick
I have premenstrual and period problems (irregular, heavy, or short periods, PMS, acne during my period).		I have irregular, light, or absent periods.		I sometimes/often have acne or spotty complexion.		I have infertility, low sperm count and/or motility, low libido or erectile dysfunction.	
My periods started early (before age 8).		My periods started late (for women only).		I'm a man with a receding hair line.		I have osteopenia/osteoporosis.	
I'm frequently exposed to plastics (plastic containers in cooking/storage, cling film, use tinned foods, drink tap water).		I have a low libido (for women only).		I'm a man who went through puberty early (before age 9).		I'm a man who went through puberty late.	
I drink alcohol most evenings, especially beer/ale and wine.		I am underweight/low percentage body fat.		I'm a woman with hair thinning down the parting.		I drink alcohol, especially beer, a lot.	
I rarely eat green vegetables like spinach and kale and/or phytoestrogen rich foods (e.g. pulses, flax).		I have a low fat, low carbohydrate, calorie restricted diet.		I'm a woman with an unusually deep voice.		I have reduced muscle mass and/or strength (men only).	
I eat a lot of sugar or carbohydrates (rice, pasta, potatoes).		I get low moods, depression, lack of motivation		I'm a woman with excessive, black hair growth.		I have been under chronic stress and/or experience low mood/depression.	
I'm on an oestrogen contraceptive pill, HRT, or other oestrogen medication.		I 've experienced long-term stress.		I eat a lot of sugar or carbohydrates (rice, pasta, potatoes).		I carry my weight around the middle (men only).	
Diagnosis or family history of one/some of: PMS (irritable), PMDD, fibroids, endometriosis, fibrocystic breasts, infertility, miscarriage, oestrogen-responsive cancer, PCOS.		Diagnosis or family history of one/some of: osteopenia/osteoporosis, infertility, menopause, hysterectomy, PMS (depressive type).		Diagnosis or family history of one/some of: PCOS, prostate inflammation/ enlargement/cancer.		Diagnosis or family history of one/some of: impotence, infertility, andropause.	
Test from a doctor or practitioner show one/some of: raised oestrogen relative to progesterone, raised 16α-OHE1: 2-OHE1, low sex hormone binding globulin, low FSH and/or LH.		Test from a doctor or practitioner show one/some of: low oestrogen, DHEA, high FSH and/or LH, sex hormone binding globulin, prolactin.		Test from a doctor or practitioner show one/some of: high testosterone and/ or DHT, high blood sugar levels, insulin, triglycerides, cholesterol, HbA1c.		Test from a doctor or practitioner show one or some of: low testosterone and DHEA, high FSH, LH and/or sex hormone binding globulin.	

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Diet

Please provide details of your typical daily food intake. Please include as much detail as possible, including quantity, type and size – for example, one large bowl of porridge made with semi skimmed milk with a handful of fresh blueberries, one cup of instant coffee with semi skimmed milk and one teaspoon of sugar.

Breakfast	Lunch	Evening Meal	Snacks
Day 1			
Time:	Time:	Time:	Time:
Day 2			
Time:	Time:	Time:	Time:
Day 3			
Time:	Time:	Time:	Time:
Drinks (including alcohol – what and how much)			

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Smoking/social drug use
Please provide details of your current and previous smoking and social drug use.

Exercise
Please provide details of your exercising habits. When, how long, what type?

Stress, relaxation & sleep
Please provide details of the level/frequency of stress, how often, how you relax, and your sleeping habits.

What would you like to achieve from these consultations?
Please provide details of your current health goals.

What are your current health and nutritional goals?

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Please provide any further detail you feel is relevant or beneficial for your consultation.

Signed		**Date Completed**	

Additional notes

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v.2 November 2021