Client filling Health Condition Assessment Form

Strictly confidential

Please fill the form as complete as possible, each table expands as you write into it. You don't have to use your real name for confidentiality but you must have an email to send you your nutritional medicinal assessment.

Client's name (Any name)			
1- Date of Birth		2- Age	
3- Gender		4-Weight in Kg:	
5- Height in cm		6- Waist in cm	
7- Hip in cm		8-Blood type	
9- Married		10- Children	
11-Occupation		12-Working time:	
13- Date			
14- Email			
15- Where you found us?			
16- Blood pressure		17- HbA1C	
18- Pulse at rest			

For office use:

1- BMI		2- Waist/hip ratio	
3-Height/2			

Important Reminder:

1- As you proceed please Answer each questions ONLY IF you know it and sure of it. Otherwise don't worry.
2- If you didn't understand something, please search for it online.
3- A term in a box is a question. Please answer accordingly.
4- The letters are in Arial 10 size. To Enlarge them click Edit, Select

all and then choose larger letter size

Health Concerns

Please describe each of your health conditions in or on any part of your body exactly one by one in the boxes bellow.

1-What are the symptoms or diseases?	
2- when did the disease/symptom start?	
3- what caused it?	
4- What triggers it?	
5- Location/s of it on/in the body?	
6- is it new or happened before?	
7- What are the symptoms?	
8- What, if any, makes it worst?	
9- What, if any, relieves it?	
10- If diagnosed by a doctor, please give full details of diagnosis.	
11- When did it start?	
Any comments?	

Please describe, in the box bellow, what improvement in your health you want in order of priority:

Previous health and medical history.

From the day of your birth up to today, please give full details of the followings in the boxes below:

1- Diseases suffered	
2- Accidents happened	
3- Medications received and reasons for them,	
4- Operation/s on your body,	
5- Born naturally or by caesarian	
6- Did the birth involve any complication to the baby or mother?	
7- Breast or bottle fed	
8- Antibiotics received	
9- If vaccinated, what type was and was there any reaction/s?	
10- Any comments?	

Supplements

If you are taking any supplements, please give full details in these boxes

1-Dosages?	
2- Reason/s for taking?	
3-Frequency of intake?	
4- Since when started taking?	
5- Doctor prescribed?	

6- Self prescribed? Like shop-bought	
7- Any Reactions?	
8- Any comments?	

Family medical and disease history

Please give full details of medical and disease history of each, if alive or passed away in the boxes bellow:

Family member	Conditions
Mother	
Father	
Grandmother (maternal)	
Grandfather (maternal)	
Grandfather (Paternal)	
Grandmother (paternal)	
Sisters/s	
Brother/s	
Any Comments	

Core Clinical Systemic Imbalance Examinations

1- **Digestive system**

Please check if you have any of these symptoms in the boxes bellow. For each one you experience, mention: 1- when happens, 2- how often happens, 3-what causes it, 4- any visible signs, 5- how it make you feel and 6- anything more.

Reflux	
Burping	

Bloating	
Halitosis	
Diarrhoea	
Frequency of bowel motions	
Constipation,	
Abdominal pain	
Urgency to go to toilet	
flatulence	
food intolerance	
mucus/blood in stools	
stool consistency (BSC)	Please copy and paste the website bellow to see which stool is like yours. Put stool number here:
Bristol Stool Chart websites	www.nhsborders.scot.nhs.uk/media/504289/Bristol-Stool-Chart.pdf
If the above website not available, search online for Bristol Stool Chart please.	

1-1-More about stools

Your stools are a good indicator of your health. There should be an easy passage, you feel completely evacuated afterwards and your stools are of the type 3–5 on the Bristol Stool Chart.

A healthy stool doesn't sink or float, mostly submerges. It is a medium brown without undigested food remnants. This is except some foods like corn or seeds which don't break down in the digestive system unless chewed very well or grounded.

Please collect some of your stool with toilet paper or other means. Check it thoroughly and then respond to the questions in the two tables bellow:

1-2- Stool Conditions

Stool conditions	Yes or no answers	For office use
1- Difficulty of passage		
2- Not fully evacuated		
3- Does it sink		
4- does it float		
5- Thin stool		
6- Dry stool		
7- Constipation		
8- Undigested food in the stool		
9- Very smelly		
10- Any comment?		

1-3- Stool Colour

Stool colour	Yes or No answers	For office use
1- Very pale / clay colour stools		
2- Green stools		
3- White mucous in stools		
4- Very dark brown stools		
5- Orange coloured stool		
6- Black tarry stools:		
7- Blood in stools		
8- Any comment?		

2- Nervous System

Please check if you have any of these symptoms in the boxes bellow. For each one you experience, mention: 1- when happens, 2- how often happens, 3-what causes it, 4- any visible signs, 5- how it make you feel and 6- anything more.

Headache	

Migraine,	
Visual disturbance	
Dizziness	
Vertigo	
Weakness	
Fainting	
Fits	
Mood changes	
Emotions	
Anxiety	
Memory	
Concentration,	
,Pins and needles	
Numbness,	
Depression	
Tinnitus.	
Any Comment	

3- Sleeping Conditions

Please check if you have any of these symptoms in the boxes bellow. For each one you experience, mention: 1- when happens, 2- how often happens, 3- what causes it, 4- any visible signs, 5- how it make you feel and 6- anything more.

Sleep Quality	
Sleep disturbances	
Vivid dreams	
Disturbed dreams	
Irregular sleep patterns	

Night sweats	
Any extra	
Any comments	

4- Stress Assessment

Work stress level	
Personal stress level	
Stress copying mechanism	
What triggers stress	
What causes stress	
Any extra comments	

5**- Hormone Production Condition (Endocrine)**

1- Blood sugar level	
2- Energy fluctuations	
3- Cravings	
4- Frequent urination	
5- Excessive thirst,	
6- weight gain or loss	
7- Fatigue	
8- Thyroid-related symptoms	
9- presence of goitre.	
10 Energy score:	Put a score from 1 to 10. 1 is poor. 10 is excellent:

	___
11- Bood PH	
12- Any comment?	

6- Reproductive systems

Females

1- Cycle length	
2- Duration	
3- Menses	
4- Previous pregnancies	
5 – Sexually transmitted diseases	
6 - Detail of any pre-menstrual symptoms	
7- Infections or thrush,	
8 - Menopause symptoms,	
9 - Libido	
10 - Fertility issues.	
11- Any comment	
Any comment	

Males

1 - libido	
2- fertility	
3-frequent or incomplete emptying of bladder,	
4- erectile dysfunction.	
5- Any sexually transmitted diseases5	
6- Any comments	

7- Defence, Immune, System

1- Allergies	
2 - Intolerances,	
3 - Wound healing time,	
5 - Asthma	
6- Eczema:	
7 - Lymphatic congestion	
8 - Urticaria	
9- Frequent infections	
10 -, Herpes	
11 - Cold sores.	
12 - Autoimmune disease.	
13 - Recent vaccinations.	
14 – Any comments?	

8 – Respiratory System

1 - Asthma,	
2 - Wheezing	
3 - Bronchitis	
4 - Post-nasal drip	
5- Mucus or sputum	
6- Sinusitis,	
7- Shortness of breath	
8 - Tonsillitis	
9 - Ear infections,	
10 - Persistent cough or dry throat	
11 – Any comments?	

9- Urinary System

1- Frequency	
2- Urgency	
3- Burning	
4- Haematuria,	
5- Loin pain,	
6- Difficulty urination	
7- Colour	
8- Smell	
9- Urinary tract infections	
10- Any comments?	

10 – Cardiovascular System

1- Chest pain	
2- Shortness of breath	
3- palpitations,	
4- Oedema	
5- Fainting,	
6- Varicose veins,	
7- Cold extremities	
8- Blood pressure	
9- Cholesterol levels	
10 - C-reactive protein	
11- Any comments?	

11- Muscle and Skeletal System

1 - Joint pain	

2- Stiffness	
3- Joint swelling	
4- Back pain	
5- Neck pain,	
6- Back Injuries	
7- Spasms,	
8- Cramps	
9- Recovery from exercise.	
10- Any comments?	

12- Skin

1- Acne	
2- Dry	
3- Oily	
4 - Eczema	
6- Contact dermatitis,	
7- psoriasis	
8- Fungal infections	
9- Sensitivity	
10- Brand of cosmetics	
11- Skincare products used	
12- Skin rashes	
13- Skin itchiness	
14- Any comments?	

13- Observational Examination

13-1: **Skin colour diagnosis**

Please mark the colour below, if any, similar to your face/skin.

1- Strong red		2- Pale red	
3- Malar flush		4- Pallor	
5- Yellow		6- Puffy	
7- Dry		8- Any comment	

13-2- Facial Observations

Facial marks		For office use
1- Number of lines, if any, across the forehead?		
2- Number of lines, if any, between eye brows?		
3- Are there purse string lines above upper lip?		
4- Are there brown shadows under eye area?		
5- Are there blue/black shadows under eyes?		
6- Any comment		

13-3- Facial skin

Issues	Yes/	Office use
1- Dermatitis (nasolabial, eyelids, in ears)		
2-Hyperpigmentation of mouth, cheek and eye areas		
3- Inelastic skin		
4- Any questions?		

13-4- **Smells**

In an adequate hygienic condition, do you think you have any of the smells bellow:

Odour name	Yes/No	For office use
Strong body odour		
Bad breath		
Smelly urine		
Smelly stool		
No smell		

13-5- Nail Diagnosis

Lunula is the whitish nail area like half moon beside the skin at the back of your nails. Please check your nails and answer when applies. You could consider to send pictures of any unhealthy nail/s.

Nail type issues	Yes or no	For office use
1-White spots like paint on the nail?		
2- Absent lunula?		
3- A pyramidal lunula		
4- A pale blue lunula		
5- A red lunula		
6- A pink or brown band at the end.		
7- Brown-grey nails		
8- Thin, brittle nails		
9- Skin infections beside a nail/s		
10- Small torn skin beside a nail/s		
11- Nail clubbing		
12- Nail spooning		
13- Grooves run across nails		
14- White bands parallel to lunula across the entire nail		
15- Longitudinal ridges		
16- Central ridges		
17- Nail pitting		
18- Nail thickening		

19- nail Beeding		
20- Nail split from nail bed.		
21-Apply gentle pressure to a nail bed and release it. After how many seconds the red came back?		

13-6- Tongue Evaluation

Please have a good look at your tongue and answer accordingly. You may send a picture/s of your tongue.

13-6-1- Tongue colour

Tongue colour	Yes/no	For office use
1-Pale		
2-Red		
3-Purple		
4- Any other colour/Comments?		

13-6-2- Tongue condition

Tongue conditions	Yes/no	For office use
1-Prominent red papillae or spots		
2-Excess papillae like hairy tongue		
3-Dry and cracked		
4- Wet		
5- Impaired taste		
6 Any comments?		

13-6-3- Tongue Shape

Tongue shapes	Yes/no	For office use
1- Thin tongue		
2-Swollen tongue		
3- Scalloped tongue		
4- Raised or upturned edges		
5- Any comments?		

13-6-4- Mobility of the tongue

Tongue tremor or quiver:		

13-6-5- Tongue Cracks

Crack types	Yes/no	For Office Use
1- Medial fissure		
2- Midline fissure at the tip:		
3- Geographical or mapped tongue		
4- Any Comments?		

13-6-6- Tongue coating

Coating type	Yes/no	Foe office use
1-Thin white		
2-Brown:		
3-Greasy yellow		
4- No coat		
5- Any comments?		

13-7- Mouth/Lips

Lip symptoms	Yes/no	Office use

1- Dry lips		
2-Angular stomatitis		
3- Any question?		

13-8- Gums/Dental

Gum issues	Yes/no	For office use
1- Bleeding		
2- Periodontal disease		
3- Pale mucous membranes		
4- Greyish mucous membranes		
5- Any comments?		

13-9- Eye

Please have a look at your eyes for any of the issues below in the table. You can send a good picture of your eyes.

Eye issues	Yes/no	Office Use
1- Contracted pupil:		
2- Dilated pupil:		
3- Dry eyes		
4- Night blindness		
5- Pale conjunctiva		
6- Blue sclera		
7- Photophobia		
8- Lack of eyelashes and eyebrows		
9- Any Comment?		

13-10- Hair

Hair issues	Yes/no	For Office use
1- Hair loss		
2- Brittle, dry and lacklustre:		
3- Perifollicular hyperkeratosis		

4- Any comments?	

14- Urine

Urine issues	Yes/no	For office use
1- Pale yellow / colourless		
2- Dark yellow/strong smelling		
3-Very dark yellow, orange or brown:		
4- Blood in urine: Red flag		
5-Unpleasant smelling / cloudy urine		
6- Normal: Straw, yellow colour		

The change of urine colour because of some foods is not an issue.

Food	Urine colour	Food	Urine colour
1- beetroot	red,	2- asparagus	green and smelly,
3- blackberries	red / brown	4- Vitamin B2	More yellow colour

15- Food intake

Please record 5 days of food and fluid intakes from Wednesday to Sundays in the five tables bellow. Please state the conditions of the food and fluids consumed. For fluids mention if they are at room temperature, warm or freeze-cold. For solid foods, if not raw please mention any cooking forms used.

Mentions your condition during the meal like if you were stressed, in good mood, walking, sitting, eating fast, chewing well, overeating.....etc.

Wednesday. Date:	time	Normal meal and any fluid	Your conditions
Breakfast			
Morning snack			
Lunch			
Afternoon snack			

Dinner			
Evening snack			
Any comment?			

Thursday. Date:	time	Normal meal and any fluid	Your conditions
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Evening snack			
Any comment?			

Friday. Date:	time	Normal meal and any fluid	Your conditions
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Evening snack			
Any comment?			

Saturday. Date:	time	Normal meal and any fluid	Your conditions
Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Evening snack			
Any comment?			

Sunday. Date:	time	Normal meal and any fluid	Your conditions

Breakfast			
Morning snack			
Lunch			
Afternoon snack			
Dinner			
Evening snack			
Any comment?			

15-1- Your Taste and Foods

Please mark each food under the same number of your taste with some thing like yes..

1- Favourites, 2- likes, 3- Preferred, 4-Dislikes, 5- Restricted/not tolerated.

Food types	1	2	3	4	5	Comments
1 -Raw Fruits						
2 - Cooked fruits						
3- Raw vegetables						
4- Cooked vegetables						
5- Dairy products						
6- Refined foods						
7- Gluten products						
8- Legumes						
9- Vegan						
10- Vegetarian						
11-Greens						
12-						

Sweet/sugary foods						
13- Tinned frozen foods						
14- Take-Ways						
15- Ready meals						
16- Frozen foods						
17- Alcohol						
18- Any comments?						

15-2- Liquid intake

Liquid Type	Time/Day	Liquid amount	Your condition and reason for drinking
1-Water			
2 - Alcohol			
3- Coffee			
4- Black tea			
5- Green tea			
6- Any herbal tea			
7- Juices			
8- Soft drinks			
9- Sugary drinks			
10- Fresh juices			
11- Any comments?			

15-3- Food Preparations and methods

Preparations/Methods	Details
1- Cooking habits	
2- Preparation methods	
3- Batch cooking,	
4- Recipes uses	
5- Budget for food	
6- Shopping habits	
7- Any limits to compliance.	
8- Raw preparation	
9- Steam cooking	
10- Boil cooking	
11- Any comments?	

16- Life Style

1- Balancing work and life	
2- What type of work	
3- Ways to unwind	
4- Practical hobbies and interests	
5- What type of exercise	
6- Exercise duration	
7- Exercise frequency	
8- Use of recreational drug	
9 -Smoking,	
10- Any comments?	

17- Dietary assessments. For office use only

Protein Animal	Animal Protein	Vegetable	Fish	Fats	Omega-3

Protein		protein			
H M L	H M L	H M L	H M L	H M L	H M L
Omega-6	Sat. fat	Trans fats	Carbohydrates	Complex carbohydrates	Simple carbohydrates
H M L	H M L	H M L	H M L	H M L	H M L
Grains	Vegetable intake	Fruit intake	Greens		
H M L	H M L	H M L	H M L		