

BLUE SKY CLINIC HEALTH QUESTIONNAIRE

Please fill this form in as best you can and bring to your first consultation at Neal's
Yard Remedies, 7 Northumberland place, Bath, BA2 7EF
01225 466944

NAME.....**DATE**.....

ADDRESS:.....
DATE OF BIRTH.....**EMAIL**.....
TELEPHONE.....
DOCTOR & SURGERY.....

HEALTH RECORD: past serious illnesses, medication & treatment:
.....
.....
.....

Have you had hepatitis or any kidney problems?.....
Have you taken many antibiotics?.....
WEIGHT.....**HEIGHT**.....

FAMILY HEALTH: family or hereditary conditions.....
.....

CURRENT HEALTH: anything you want to be treated, symptoms and duration
1.....
2.....
3.....
4.....
5.....

CURRENT MEDICATION.....
.....

SUPPLEMENTS.....
.....
.....

HOBBIES:.....

OCCUPATION:.....

DIGESTION
Is your appetite:

- Erratic
- Sluggish
- Good
- Balanced

Do you suffer from:

- Wind or bloating
- Heartburn
- Bad breath
- Bleeding gums
- Food intolerances
- Do you get very thirsty?

Which is your favourite flavour?: sweet salty sour spicy bitter astringent

BREAKFAST.....

LUNCH.....

SUPPER.....

SNACKS..... **DRINKS**.....

Do you eat?: Salt Sugar Coffee Tea Chocolate
 High fat content foods Alcohol

List % of these foods in your diet: raw food cooked food meat
 fish dairy vegetables 'junk' foods pastries/biscuits
 Are you vegetarian.....vegan..... Since when?.....

ELIMINATION

Bowels:

- Do you have a daily bowel movement?
- Do you have diarrhoea?

Number of times/day _____ time of day _____ malodorous _____

- Do you have constipation?

How long for? _____ Causes _____ Piles _____

Urination:

No. of urinations/day _____ Dribbles _____ Pain _____ Urgency _____
 Colour _____ Cloudy Red Pale Yellow

- Do you urinate at night?

Sweat:

- Do you sweat easily?
- Do you sweat at night?

IMMUNITY

How many colds/flu do you get a year _____

Do you have any allergies? _____

eczema psoriasis asthma migraine irritable bowel bloating
 hay fever nasal drip swellings inflammation thrush
 candida cystitis cold sores

VITALITY

- Do you feel hot?
- Do you feel cold? extremities only knees/ lower back
- Do you have good energy? morning midday afternoon evening
- Are you muzzy headed in the morning?

- Do you generally feel tired?

EMOTIONS

What is your predominant emotion?

Are you easily: -Irritable Impatient Depressed Tearful Fearful
Do you have excess stress in your life?

SLEEP

- Do you get to sleep easily?
- Do you wake up in the night? What time?:
Average number of hours/night _____
- Do you feel rested when you wake up?

WOMEN

Cycle length _____ How many days does your period last? _____

Do you suffer from:

- Pain When? _____
- PMS What? _____
- Breast distension
- Clots
- Migraines at menstruation When? _____
- Food cravings What? _____
- Low libido
- Excess libido

Colour of blood: Light Medium Dark

Type of contraception:

How long:

Are you pregnant?:

Do you have children?:

Are you trying to conceive?

Age of: Menarche

Pregnancy

Menopause

MEN

Do you suffer from:

- Excess urination
- Low libido
- Impotence
- Excess libido
- Infertility

HEART

- Is there a history of heart disease in your family?:
- Do you have palpitations: When?:.....
- Do you/have you smoked: Years No./day
- Do you eat high fat foods or red meat:

What is your Blood Pressure?:

RESPIRATION

- Have you ever had breathing difficulties?
- Do you wheeze: Cause?:.....
- Do you cough mucus: When Colour.....
- Do you regularly have a blocked nose? Cause?:.....

