

HEALTH QUESTIONNAIRE

7 Northumberland Place, Bath T : 01225 466944

Please fill this form in as thoroughly as possible.

All the medical information contained here is confidential will not be released to any person except with your written permission. Please bring relevant medical results and information with you to the consultation.

Personal details

Surname: Title: (Mr, Mrs, Ms, Miss)

Forename(s): Date:

Date of Birth: Age:

Email: Address:

Tel No:

Doctor & Surgery

Occupation: Hobbies:

Marital status: Married Single Children (Ages)

.....

Health record Past serious illnesses, medication & treatment:

Condition	Date	Treatment	Medication

Have you had hepatitis or any kidney problems? If yes when?

Have you taken many antibiotics? If yes what for and when?

Weight: Height:

Are you being treated by any other practitioner at the moment? If yes please list details

.....

Family health Family or hereditary conditions:

Mother	
Father	
Grandparents	
Siblings	

Current health Anything you would like to be addressed:

Condition	Symptoms	Duration

Current supplements

Name	Brand name	What is it for?	Strength	Dose	Frequency

Current medications

Name	Brand name	What is it for?	Strength	Dose	Frequency

Digestion Is your appetite (sensation of hunger):

- Erratic
 Sluggish
 Good
 Too good
 Balanced
 Do you get very thirsty?

Do you suffer from:

- Wind or bloating
 Heartburn
 Nausea
 Bad breath
 Bleeding gums
 Ulcers
 Irritable bowel syndrome
 Abdominal pain
 Liver problems
 Gallstones
 Food intolerances: If yes what?

Which is your favourite flavour?
 Sweet
 Salty
 Sour
 Spicy
 Bitter

What do you have for the following meals?

Breakfast	
Lunch	
Supper	
Snacks	
Drinks	

Diet For the following foods please list percentage in your diet:

Raw food 'Junk' food Meat Fish Dairy Vegetables Cooked food Pastries / Biscuits
% % % % % % % %

How much water do you drink? glasses/day

Do you drink alcohol? Yes No If yes, what types? (Spirits, Beer) How often?
Times/week

Do you drink coffee? Yes No How much? cups/day

Do you drink tea? Yes No How much? cups/day

Are you vegetarian? Yes No If yes since when

Are you vegan? Yes No If yes since when

Elimination Bowels

Do you have a daily bowel movement? Yes No If yes please tick a box -1 1 2 3 +4

Do you have constipation? Yes No If yes how long for?

Do you have haemorrhoids? Yes No

Do you have diarrhoea? Yes No

Do your stools:

Show blood Sink Have Mucus Float No odor Have a bad odor

Immunity

Do you suffer from any of the following conditions?

Cystitis Cold sores Nasal drip Thrush Eczema Inflammation

Psoriasis Hay fever Candida Migraine Irritable bowel Asthma

Other

Do you have strong immunity? How many colds/flu do you get a year?

Urination

Please tick boxes that apply to you:

No. of urinations/day: Is the colour: Cloudy Red Pale Yellow

Do you urinate at night? Water retention Interstitial cystitis

Painful urination Frequent urination Blood in urine

Urgency of urination Kidney/bladder stones Burning urine

Decrease in flow Prostate enlargement Irregular flow

Difficulty stopping or starting Inability to hold urine

Metabolic vitality

Please tick boxes that apply to you:

Erratic energy Night sweats Frequent fevers

Chronic fatigue Slow metabolism Chills

Sudden energy drops Do you generally feel tired? Recent weight gain

- Do you feel hot? Intolerance to heat or cold Recent weight loss
- Do you feel cold? Excessive thirst Do you sweat easily?
- Are you muzzy headed
in the morning?

When is your energy best? Morning Midday Afternoon Evening

Mind and emotions

How do you feel about the following areas of your life? Please check appropriate boxes and make any additional comments if you would like to.

	Excellent	Good	Fair	Poor	Comments
Yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Life purpose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Spouse / Partner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Are you able to express your feelings and emotions easily? Yes No

Is there an excess of stress in your life? Yes No

If yes, what is causing you so much stress?

Do you have tools or techniques to relieve stress? Yes No

If Yes what are they?

Are you satisfied with your current living/working environment? Yes No

If there is one thing in your life that you would like to change right now, what is it?
.....

Are you a 'nervous type' person? Yes No

If yes, what things make you most nervous?

What feelings do you most often experience in your life?

- Joy Happiness Anger Sadness Fear Anxiety Worry Depression

Men's reproductive health Do you suffer from:

- Excess urination Low libido Excess libido
 Infertility Impotence Prostate enlargement

Women's reproductive health

Date of last period Cycle length How many days does your period last?

Do you suffer from: Pain When and please describe?

Migraines at menstruation When?.....

Food cravings What?.....

Breast distension

Clots

Low libido

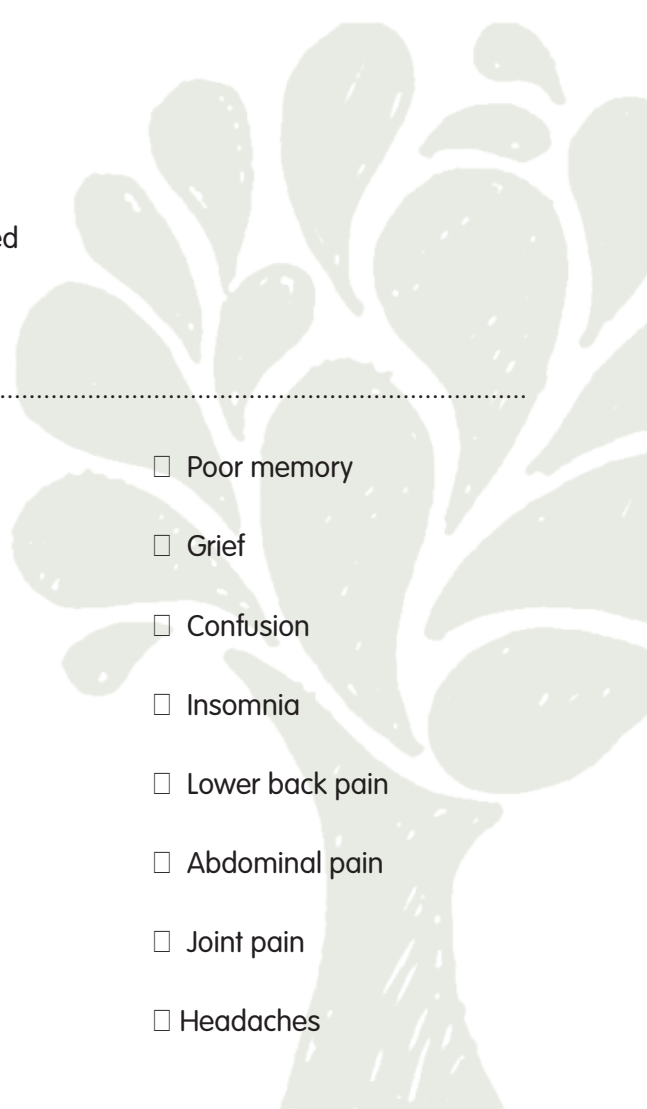
Excess libido

Colour of blood: Light red Medium red Dark red

Do you suffer from PMS?

What happens?.....

- | | | |
|---|--|--|
| <input type="checkbox"/> Low libido | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Poor memory |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Grief |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Breast tenderness | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Bloating | <input type="checkbox"/> Lower back pain |
| <input type="checkbox"/> Craving for sweets | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Water retention | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Depression | <input type="checkbox"/> Headaches |



Type of contraception:

Do you or have you recently used contraceptive pill? Yes No

If yes, which one?

Do you use: IUD Condoms Diaphragm For how long?

Are you pregnant? Yes No Are you trying to conceive? Yes No

How many pregnancies? Do you have children? Yes No

Age during (if applicable): Menarche Pregnancy Menopause

Have you had / do you have?

- | | | |
|---|---|--|
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Irregular PAP smear | <input type="checkbox"/> Ablation | <input type="checkbox"/> D&C |
| <input type="checkbox"/> Interstitial cystitis | <input type="checkbox"/> Irregular bleeding | <input type="checkbox"/> Pain with intercourse |
| <input type="checkbox"/> Dryness with intercourse | <input type="checkbox"/> Infertility | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Lumpectomy | <input type="checkbox"/> Yeast infections |

Sleep

Do you get to sleep easy? Yes No

Do you feel rested when you wake up? Yes No

Do you wake up in the night? Yes No

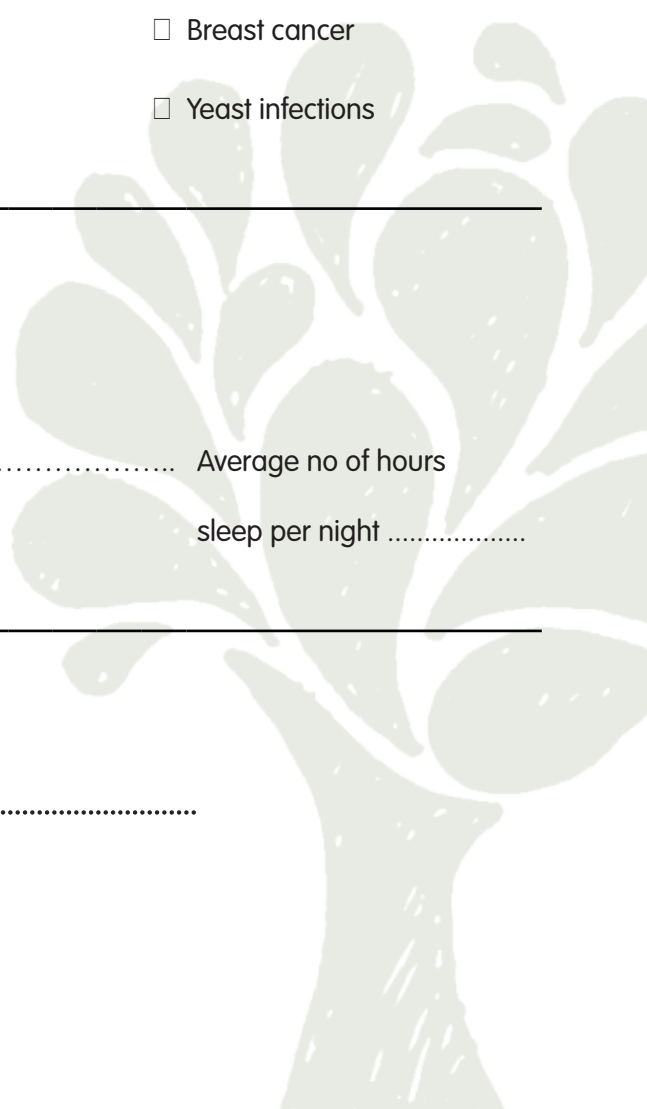
What time? Average no of hours sleep per night

Heart

Is there a history of heart disease in your family? Yes No

Do you have palpitations? Yes No When?

Do you eat high fat foods or red meat? Yes No



What is your Blood Pressure? High or Low blood pressure

What is your cholesterol level? HDL.....LDL.....Triglycerides

Do you suffer from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Chest/heart pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Ankle swelling | <input type="checkbox"/> Palpations |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Blood clots |

Skin and Hair Do you suffer from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Hives | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Poor healing sores | <input type="checkbox"/> Itching | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Recent moles | <input type="checkbox"/> Recent changes in skin texture | <input type="checkbox"/> Visible broken veins |

Any other noted problems with your skin, nails or hair?

.....

.....

Head, Eyes, Ears, Nose and Throat Do you suffer from:

- | | | |
|---|---|---|
| <input type="checkbox"/> Poor vision | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Floaters | <input type="checkbox"/> Eye pain | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Earaches | <input type="checkbox"/> Canker sores |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Facial pain | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Mucous in throat | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Cold sores, if yes |
| <input type="checkbox"/> Swollen glands | <input type="checkbox"/> Frequent colds | how often? |

Any other problems with your head, eyes, ears, nose or throat?

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Respiration

Have you ever had breathing difficulties? Yes No

Do you wheeze? Yes No

Cause?

Do you cough mucus? Yes No

When and colour

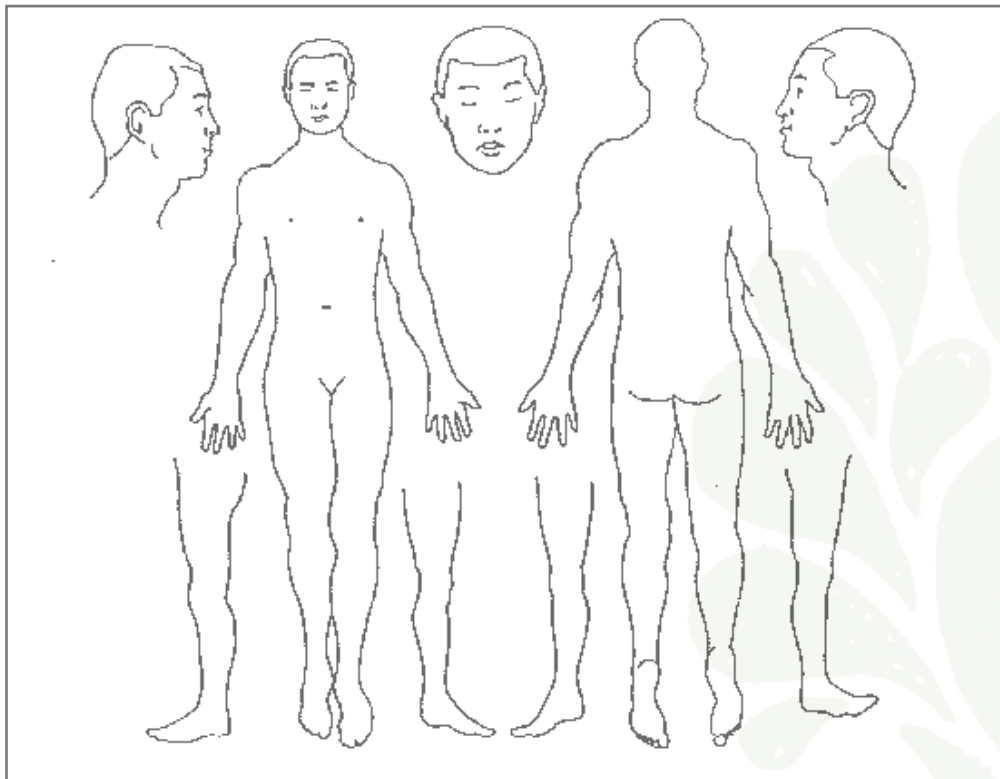
Do you regularly have a blocked nose? Yes No

Do you / have you smoked? Yes No

Pain

Do you have any pain(s)? Yes No

Please indicate painful or distressed areas below:



Area / Description of symptoms	Pain level: Low 0 - 10 High	Frequency

Musculoskeletal Please tick boxes that apply to you:

- | | | |
|--|--|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> General muscle pain | <input type="checkbox"/> Muscle weakness |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> General stiffness | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Back pain | <input type="checkbox"/> Reduced movement |

Eyes

Colour: Brown Light OR Dark

Blue Green

Sclera: Yellow Red White

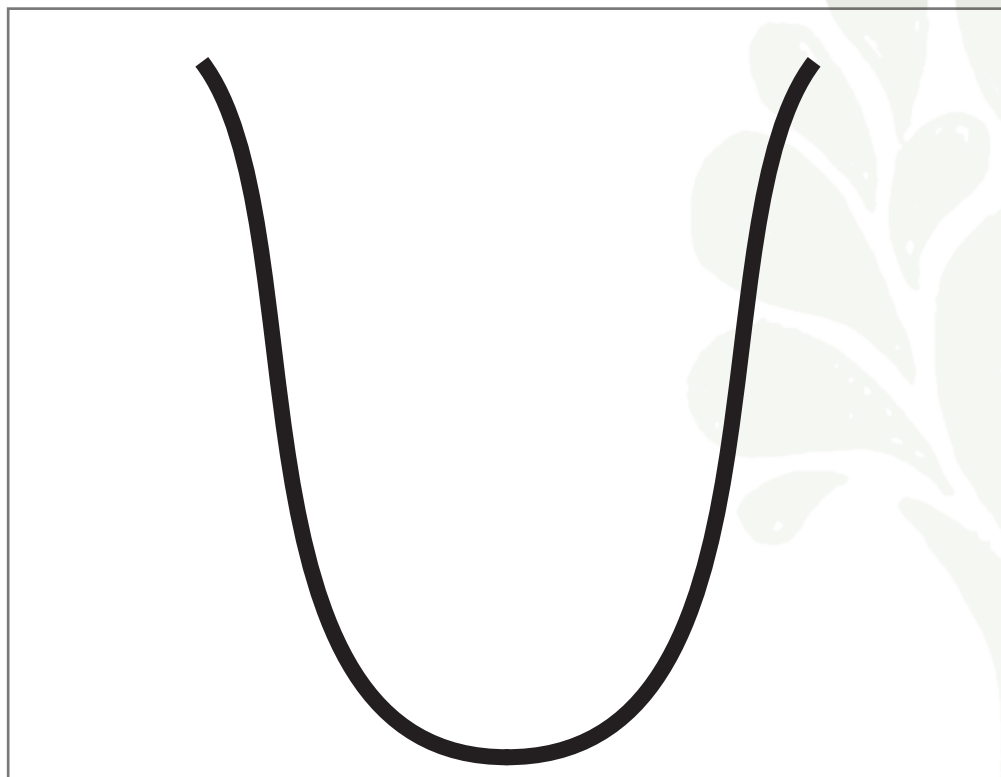
Pulse

Rate: Depth: Quality: Skin Feeling:

Tongue

Colour : Shape: Coating: Markings:

Tongue diagram:



For diagnosis only

Vikriti: V P K

Prakriti: V P K

Dhatu:

Rasa Rakta Mamsa Meda Asthi Majja Shukra Arthava

Manas

S R T S R T

LHS:

Ht/SI

Liv/Gb

Bl/Si

RHS:

Lu

Sp/St

Kid/LI

YIN/ YANG

FULL/ EMPTY

HOT/ COLD

INTERIOR/ EXTERIOR

DAMP/ DRY

Qi

Blood

Fluids

Vikriti: V P K

Prakriti: V P K

Dhatu:

Agni:

Koshta:

Ama:

Diagnosis:

TP:

Prescription

Formula:

Disease:

Dosha:

Dhatu:

Agni:

