

## Health statement

Date: \_\_\_\_\_

<i>Name</i>
<i>Address</i>
<i>Telephone</i>
<i>E-mail</i>
<i>What is your main reason for seeking consultation?</i>
<i>What remedial measures, if any, have you already tried?</i>
<i>Prescription drugs used, including oral contraceptives, in significant doses: more than 5 years ago, in the past 5 years, in the past year</i>
<i>Any nutritional supplements you are currently taking: product name, dosage, manufacturer</i>
<i>Head: dizziness, fainting spells, headaches, migraines</i>
<i>Eyes: vision, itching, discharges, impaired night vision, eye glasses, contact lenses</i>
<i>Ears, nose and throat: itching, mucus, dryness, hearing, sores, infections</i>
<i>Mouth: dryness, sores, bleeding gums, sore tongue, cracked tongue surface, tongue residue, blisters, metallic taste</i>
<i>Teeth: amalgam fillings, metal alloys, root canals, grinding of teeth, excessive tooth decay, loosening of teeth, tooth aches, purging of amalgam fillings</i>
<i>Liver: test results, opinions cited by other practitioners, sensitivity to chemicals, skin itching, unexplained rashes</i>
<i>Stomach: gastritis, nausea, pain, bloating, burping, acid indigestion, heartburn etc</i>
<i>Gall bladder: known problems, surgery, gall stones, discomfort on ingestion of fatty foods, difficulties gaining or losing weight</i>
<i>Intestines: lesions, gas, upset stomach, cramps, constipation, diarrhea, blood, rectal itching</i>
<i>Faeces: hard, soft, runny, watery, mucus, undigested food, "floaters", colour</i>

<i>How often do you have a bowel movement? What time of day, usually?</i>
<i>Immune system: colds, flu, stomach bugs, frequent illness, recurring infections of the same type</i>
<i>Antibiotic use: earlier in life, recent years, in the past year</i>
<i>Lungs: bronchial problems, asthma, smoking</i>
<i>Kidneys / urinary tract: needing to pass water at night, known problems, back pain, infections, frequent urination, burning sensations</i>
<i>Hair: lifeless, abnormal hair loss, early greying, slow growth</i>
<i>Skin problems: eczema, itching, acne, rashes or redness, excessive perspiration, dryness, broken blood vessels, easily bruised, fungal infections</i>
<i>Circulation: blood pressure, angina, cold hands and feet, numbness, tingling</i>
<i>Heart: palpitations, irregular heartbeat, heart failure, pulse, oedema of the legs, chest pain, physician's diagnosis</i>
<i>Male reproductive organs / prostate: infertility, impotence, urinary problems, inflammations, fungal infections</i>
<i>Are you pregnant or breast feeding?</i>
<i>When was your last menstrual period?</i>
<i>Female reproductive organs: (previous or current), myoma, endometriosis, cysts, infertility, miscarriages, pregnancies, yeast infections, irregular or painful periods or excessive menstrual flow, PMS, fragile mucous membranes, loss of sexual drive</i>
<i>Menopausal problems: (previous or current), hot flashes, sleeping problems, psychological problems, fragile mucous membranes</i>
<i>Skeleton / cartilage: slipped discs, worn out joints, fractures, bone deficiency, broken bones, calcification, scoliosis</i>
<i>Joints: stiffness, pain, impaired movement, swelling</i>
<i>Muscles: pain, swelling, stiffness, cramps, spasms, slackness, tension</i>
<i>Known and suspected allergies and hypersensitivities: air borne, fragrances, electricity, food allergies etc</i>
<i>Food stuffs which you suspect disagree with you</i>

<i>Food stuffs which you know that you respond well to</i>
<i>Food stuffs you crave (even if you don't eat them), such as coffee, sweet, sour, salty or spicy flavours, fats</i>
<i>Drinking water: private well, municipal water, purified water, specially treated water, properties of the water</i>
<i>What do you usually eat for breakfast?</i>
<i>How many hours after breakfast before you need another meal?</i>
<i>What do you usually eat for lunch? Home cooked, restaurant meal, microwaved food, ready-cooked food, homely fare</i>
<i>What do you usually eat for dinner?</i>
<i>How many fruits do you eat daily?                      What quantities of vegetables, in average number of decilitres per day?</i>
<i>Which symptoms do you experience when hungry? Dizziness, faintness, irritation, trembling, stomach pains, are you hungry frequently or seldom</i>
<i>Coffee and alcohol consumption: how much?</i>
<i>Weight: over- or underweight, compulsive eating, food addictions, eating disorders, difficulties gaining or losing weight</i>
<i>Exercise habits: frequency, types of activity</i>
<i>Surgical history</i>
<i>Energy levels: tired, exhausted, unenterprising, hyperactive, normal energy, tired at specific times of day, very uneven energy levels</i>
<i>Sleep: fall asleep but wake up again during the night, difficulty falling asleep, wake up too early, sleep too lightly, sleep too deeply, not enough sleep, too much sleep</i>
<i>Emotions: mood swings, anxiety, fears, irritability, sadness, worry, lack of emotional control, don't recognize yourself</i>
<i>Senses: problems concentrating, memory, slow reactions, speech problems, learning disabilities, indecision</i>
<i>Work / studies: satisfaction, level of influence over your own situation, growth potential, level of responsibility, colleagues, superiors, working environment, occupation, studies, feedback</i>
<i>If you had unlimited possibilities to realize your highest dreams, what would you be doing? If you're not doing this, why not?</i>

*Stress: trauma, illness, toxic symptoms, financial concerns, performance anxiety, control issues, responsibility for others, inner stress*

*Current family: spouse / partner / significant other / single / children / pets*

*Close family relationships: do you feel safe, do you feel fully seen and heard, mutual respect, conflicts, accepting responsibility, team work, intimacy, co-dependency, loneliness etc*

*Do you have opportunities for daily rest and recuperation in your home?*

*How was your relationship with your parents and siblings as a child?*

*What chief character traits would you use to describe your parents or childhood guardians?*

*Previous treatment by health practitioners / physicians: type of treatment, name and year of treatment*

*Miscellaneous:*