LANSERHOF | AT THE ARTS CLUB

NEW PATIENT NUTRITIONAL THERAPY QUESTIONAIRE

Please complete this form using CAPITAL LETTERS and bring it with you to your first appointment.
This information is confidential.

Title: Mr / Ms / Mrs / Miss / Other (Please specify): _____

Name: _____

Address: _____

_____ Post Code: _____

Home Tel: _____ Work Tel: _____ Mobile: _____

E-mail Address: _____ Date of Birth: _____

Marital Status: _____ Occupation: _____

Ages of Children: _____

GP's Name: _____ GP's telephone: _____

GP's Address: _____

_____

Do you wish your GP to be informed of your visit? Yes / No

1. HISTORY OF CURRENT PROBLEM

In the space below, please outline the problem(s) that have led to your visit.
You should mention all significant complaints, as there may be a relationship between them.

PROBLEM *eg. Migraine*	Onset *eg. June 2000*	Frequency *eg. 1x week*	Severity *eg. Moderate*

GOALS: Please state three things you are looking to improve as a result of the programme.

1. _____
2. _____
3. _____

When did you last feel truly well? _____

2. YOUR MEDICAL HISTORY

In the space below, please outline the problem(s) that have led to your visit.
You should mention all significant complaints, as there may be a relationship between them.

I. Were you born with any medical condition? Yes / No
If yes, please list: _____

II. OPERATIONS: Please list any operations you have had (stating exactly when).
eg. tonsillectomy, hernia, gall bladder, hysterectomy, appendectomy

_____
_____
_____

III. MEDICATION: Please list.

_____
_____
_____

VI. SUPPLEMENTS *Vitamins, Minerals, Herbs, etc.*

NAME *(Product & Company)*	Strength	How Many Daily	How Long

** It would be helpful if you could bring these with you to your consultation*

V. ALLERGIES: Food or Environmental

_____
_____

3. MEDICAL COMPLAINTS

Do you have any problems currently or recently in the past with:

ENERGY

- ☐ Excessive tiredness by early evening
- ☐ Weak muscles most of the time
- ☐ Frequent feeling of too cold
- ☐ Frequent feeling of too hot
- ☐ Tiredness after exercise

DIGESTION

- ☐ Eat more than is good for you
- ☐ Change of weight more than 5lb in last year
- ☐ Chew your food well
- ☐ Pain on swallowing
- ☐ Frequent heartburn or stomach pains
- ☐ Cramps, bloating or gas after eating
- ☐ Long standing diarrhoea
- ☐ Long standing constipation
- ☐ Change in bowel habits
- ☐ Bleeding or very dark bowel movements
- ☐ Haemorrhoids, rectal itching
- ☐ Bad breath
- ☐ Coated tongue

WOMEN ONLY

- ☐ Irregular periods
- ☐ Heavy periods
- ☐ Cramps during period
- ☐ Bloating or unwell before periods
- ☐ Premenstrual headaches or irritability
- ☐ Vaginal infections, irritation, discharge
- ☐ Abnormal smear test
- ☐ Pain during sex
- ☐ Vaginal dryness
- ☐ Painful breasts pre-period
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Hot Flashes
- ☐ Night sweats
- ☐ Infertility problems

GENITO URINARY

- ☐ Pain or discomfort passing urine
- ☐ Difficulty starting or controlling urination
- ☐ Too frequent urination
- ☐ 2 or more urinations in a night
- ☐ 3 or more urinary infections in past year
- ☐ Sexual difficulties
- ☐ Loss of Libido

HEAD

- ☐ Severe or frequent headaches
- ☐ Convulsions, fits, epilepsy
- ☐ Blackouts, collapsing
- ☐ Vision or eye problems
- ☐ Ringing in ears/deafness
- ☐ Foggy brain
- ☐ Dizziness
- ☐ Changes in taste or smell
- ☐ Facial puffiness

RESPIRATORY

- ☐ Shortness of breath
- ☐ Shortness of breath on physical exertion
- ☐ Persistent cough or wheezing
- ☐ Coughing phlegm or blood
- ☐ Frequent sneezing or hay fever
- ☐ Persistent or frequent colds
- ☐ Sinus problems
- ☐ Nose bleeds

LIMBS

- ☐ Aching joints, arthritis
- ☐ Numbness, tingling, shooting pains
- ☐ Repeated cramps or spasms in muscles
- ☐ Varicose veins
- ☐ Swelling in hands or feet
- ☐ Cold feet or hands most of the time
- ☐ Troublesome back pain
- ☐ Troublesome neck pain

CARDIOVASCULAR

- Repeated tightness or pain in chest ☐
- Heart beating often, irregularly/ very fast ☐
- High blood pressure ☐
- Dizziness, fainting ☐
- High Cholesterol ☐

MENTAL

- Tired ☐
- Foggy head ☐
- Lack of ambition ☐
- Inability to make decisions ☐
- Feeling depressed, down, upset ☐
- Crying too often for no reason ☐
- Difficulty falling asleep or waking up ☐
- Disturbing dreams ☐
- Poor memory ☐

SKIN

- Dry ☐
- Oily ☐
- Acne/recurrent boils ☐
- Hives ☐
- Itchiness ☐
- Rashes ☐
- Sun sensitive ☐
- Easy bruising ☐
- Dandruff ☐
- Hair loss ☐
- Excessive hair ☐
- Lumps, swelling under skin ☐
- Excessive sweat or body odour ☐
- Warts ☐

4. FAMILY MEDICAL HISTORY

	Age	Alive/Deceased	Medical Problems
Mother			
Father			
Brother/Sister			
Brother/Sister			
Brother/Sister			
Brother/Sister			

Any known family history of:

Heart Disease ☐	Jaundice ☐	Diabetes ☐	Obesity ☐
Osteoperosis ☐	Thyorid ☐	Arthritis ☐	Epilepsy ☐

5. SOCIAL HISTORY

EXERCISE/ACTIVITY

What exercise will you do in a week? _____

_____

Do you practice yoga, tai-chi, qi-qong? Yes / No
Do you feel improved after exercise? Yes / No
Do you feel pains or tired after exercise Yes / No
Do you go to a gym regularly Yes / No
If yes, how many times per week? _____

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STRESS

Do you have problems coping with marriage, family, friends? Yes / No
Do you have excessive financial or job security problems? Yes / No
Do you work under pressure? Yes / No
Do you sleep well? Yes / No
Do you frequently travel or commute long distances? Yes / No
Do you regularly relax, meditate, pray? Yes / No

Do you enjoy your job? Love ☐ It's okay ☐ Don't like it ☐ Hate it ☐
How much time have you lost from work/school in the last year?

DIET

1. How many meals do you eat in a day? _____
2. How many meals daily do you spend 20 minutes or more at a table? _____
3. Daily average: Cups of coffee _____
   Cups of regular tea _____
   Glasses of soft (soda) drink _____
4. Do you normally have an alcoholic beverage on most days? Yes / No
5. How many units do you drink in a week? (1unit = 1 small glass of wine, ½ pint beer)

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6. Do you smoke? Yes / No
7. How many per day? _____
8. How many years have you smoked for? _____
9. Do you, or have you used any recreational drugs regularly? Yes / No
10. What foods do you crave or like strongly? _____

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11. Do you feel weak or sick if you do not eat? Yes / No
12. Do you feel unwell or hungry after you eat? Yes / No
13. What foods or beverages do you avoid, do not like? _____

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14. Do you crave sugar or sweet food? Yes / No
15.
15. What is your ideal weight? _____
    Present weight _____ Present height _____

16. Are there any other comments/information which you feel may be important?

This document represents a complete summary of my medical history

_____ _____
Signed Date