

Private & Confidential

Diet & Symptom Analysis

Reference (leave blank) _____

Name _____

 Male Female

Address _____

Telephone _____

Physician's name & address _____

Date of birth _____

Weight in kilos _____

Height in metres _____

- Lifestyle risk factors
- I work in a sealed building
- I work with chemicals
- I suffer chronic high stress levels
- I rarely go outdoors
- I rarely get any exercise

Daily smoking habits

0	10-20
1-10	20+

Amalgam (silver) tooth fillings

0	5-9
1-4	10+

- Current medications
- Beta-blockers
- Contraceptive pill or HRT
- Pain-killers
- Anti-inflammatory steroids
- Others (specify) _____

- Antibiotics history
- Never taken
- Occasional past use
- Frequent past use
- Long-term past use
- Long-term current use

Have you had surgery to remove gall-bladder, stomach or intestines?

 Yes No

What illnesses run in the family?

Current health problems 1) _____

2) _____

3) _____

4) _____

What helps these problems? _____

Or makes them worse? _____

Women Only

Number of pregnancies	0	1-2	3-4	5+
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- Are you pregnant now?
- Breastfeeding?
- Are you prone to miscarriages?

Your Eating Habits (everyone) Honesty is essential. Circle as appropriate.**PER WEEK**

Alcoholic drinks per week	0	4-7	15-21	
	1-3	8-14	22+	
Portions of red meat per week	0	4-7		Portion= 100g/4oz. Include ham, sausages, salami, burgers, etc.
	1-3	8+		
Portions of white meat per week	0	4-7		Portion= 100g/4oz. Chicken, turkey etc. Excludes fish.
	1-3	8+		
Portions of fish or seafood per week	0	4-7		Portion = 100g/4 oz excluding bones
	1-3	8+		
Portions of dairy items per week	0	4-7		Portion of cheese, yoghurt, milk pudding or glass of milk
	1-3	8+		
Number of eggs per week	0	4-7		
	1-3	8+		
Portions vegetable protein per week	0	4-7	15-21	Nuts, beans, lentils, soya products, mycoprotein etc.
	1-3	8-14	22+	
Portions deep-fried food per week	0	4-7	15+	Chips (fries), fried chicken and all items deep-fried in batter
	1-3	8-14		
Pre-cooked reheated meals/week	0	4-7	15+	Commercial microwave or freezer meals, TV dinners ready-to-heat pizzas etc.
	1-3	8-14		
Portions canned or instant food/week	0	4-7	15+	
	1-3	8-14		
Sweet flour or cereal items/week	0	4-7	15+	Sweetened cereals, cake or sweet pastry, or 50 grams of sweet biscuits
	1-3	8-14		
Portions of ice cream per week	0	4-7	15+	
	1-3	8-14		
Portions of other desserts/week	0	4-7	15+	Sweets, creamy sugary desserts, puddings., pies. Excludes fresh fruit.
	1-3	8-14		
Chocolate or candy bars/week	0	4-7	15+	Bar size approx 100 g or 3 oz
	1-3	8-14		
Bags of crispy snacks per week	0	4-7	15+	
	1-3	8-14		
Tbsps of oil per week	0	4-7		Olive, sunflower, safflower, groundnut/peanut oil etc.
	1-3	8+		
Use of margarine per week	0	4-7	15+	Portion size = about one tablespoon or amount in one sandwich
	1-3	8-14		
Use of butter per week	0	4-7	15+	Portion size = about one tablespoon or amount in one sandwich
	1-3	8-14		

PER DAY

Glasses of water per day	0	2-3		About 300 ml, half a pint or one US cup
	1	4+		
Soft drinks per day	0	3-4		
	1-2	5+		
Cups of tea or coffee per day	0	4-6		Including caffeinated and decaffeinated. Excludes herbal teas.
	1-3	7+		
Spoons of sugar per day	0	5-10		Total number added per day to drinks or cereal
	1-4	11+		
Artificial sweeteners per day	0	2		Includes pills, granules and portions of "diet" products
	1	3+		
Portions fresh vegetables per day	0	3-5		(Per handful of pieces) in soup, salad, casseroles or served separately.
	1-2	6+		
Portions fresh fruit per day	0	2	4	
	1	3		
Portions whole-grain items per day	0	2	4	Whole-wheat, rye, oats (porridge etc), brown rice, cornflakes
	1	3	5	
Portions white flour items per day	0	2	4	White bread, white rice or pasta, croissants
	1	3	5	
Salt consumption	Light	Med-ium	Heavy	Heavy use includes frequent consumption of salty or smoked foods

Please tick any symptoms below which seem *particularly* to apply to you in recent times

Eyes	
Focussing problem in bad light	<input type="checkbox"/>
Always sore, dry or bloodshot	<input type="checkbox"/>
Very sensitive to bright lights	<input type="checkbox"/>
Ears	
Persistent itching in ears	<input type="checkbox"/>
Deafness	<input type="checkbox"/>
Skin and Fingernails	
Spotty skin (acne)	<input type="checkbox"/>
Dry, flaky skin	<input type="checkbox"/>
Persistent dandruff	<input type="checkbox"/>
Pale skin	<input type="checkbox"/>
Itchy red patches	<input type="checkbox"/>
Eczema	<input type="checkbox"/>
Sore, raw tongue	<input type="checkbox"/>
Cracked lips	<input type="checkbox"/>
Sores that won't heal	<input type="checkbox"/>
Split or brittle fingernails	<input type="checkbox"/>
White-spotted fingernails	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>
Burning sensations	<input type="checkbox"/>
Immune System	
Frequent colds or infections	<input type="checkbox"/>
Persistent thrush (yeast infections)	<input type="checkbox"/>
Muscles	
Cramps, twitching or spasms	<input type="checkbox"/>
Weakness	<input type="checkbox"/>
Pain	<input type="checkbox"/>
Muscles knotted—won't relax	<input type="checkbox"/>
Circulation	
Tendency to high cholesterol	<input type="checkbox"/>
Irregular heartbeats	<input type="checkbox"/>
Palpitations	<input type="checkbox"/>
Sensitive to cold	<input type="checkbox"/>
Hot flushes	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>
Hormones	
Premenstrual symptoms	<input type="checkbox"/>
Painful menstrual periods	<input type="checkbox"/>
Heavy periods	<input type="checkbox"/>
Absence of periods(before the menopause)	<input type="checkbox"/>
Breast tenderness	<input type="checkbox"/>
Enlarged prostate	<input type="checkbox"/>
Dizzy, shaky or headache if you miss a meal	<input type="checkbox"/>
Unexplained weight gain	<input type="checkbox"/>
Brain & Nervous System	
"Spaced-out" feeling	<input type="checkbox"/>
Deteriorating co-ordination	<input type="checkbox"/>
Deteriorating memory	<input type="checkbox"/>

Increasing confusion	<input type="checkbox"/>
Mood swings	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>
Tremors	<input type="checkbox"/>
Easily startled	<input type="checkbox"/>
Nervousness	<input type="checkbox"/>
Panic or anxiety attacks	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>
Depression	<input type="checkbox"/>
Irritability	<input type="checkbox"/>
Psychiatric problems	<input type="checkbox"/>
Hyperactivity	<input type="checkbox"/>
Bones	
Pain and tenderness	<input type="checkbox"/>
Brittleness (osteoporosis)	<input type="checkbox"/>
Miscellaneous	
Easy exhaustion	<input type="checkbox"/>
Breathlessness	<input type="checkbox"/>
Poor appetite	<input type="checkbox"/>
Poor sense of taste or smell	<input type="checkbox"/>
Constipation	<input type="checkbox"/>
Gall bladder problems	<input type="checkbox"/>
Great thirst	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>
Food Intolerance Symptoms	
Chronic fatigue or drowsiness	<input type="checkbox"/>
Head feels "foggy"	<input type="checkbox"/>
Sudden unprovoked aggression	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>
Frequent severe headaches	<input type="checkbox"/>
Chronic diarrhoea	<input type="checkbox"/>
Tummy griping or mucus discharge	<input type="checkbox"/>
Painful or tender joints	<input type="checkbox"/>
Frequently congested sinuses	<input type="checkbox"/>
Fluid retention	<input type="checkbox"/>
Chronic catarrh	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>
Dark colour under eyes	<input type="checkbox"/>
Tummy discomfort gas & bloating	<input type="checkbox"/>
Detoxification Issues	
Feels "hung-over" despite no alcohol	<input type="checkbox"/>
Often slightly nauseous	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>
Yellowish skin or eyes	<input type="checkbox"/>
Great lethargy	<input type="checkbox"/>
Bad reactions to chemicals	<input type="checkbox"/>
Unwell after coffee or a little alcohol	<input type="checkbox"/>
Tenderness under right-hand ribs	<input type="checkbox"/>
Premenstrual mood changes	<input type="checkbox"/>
History of breast or uterus cysts, tumours, fibroids, endometriosis	<input type="checkbox"/>
Ever abused drugs or alcohol?	<input type="checkbox"/>