Thank you for taking the time to fill out this form and provide me with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. Please remember to save along the way. Once you are ready to send it back, attach it to an email and send to health@anitabhikha.com or post to Anita Bhikha-Willan, 507b Southland Rd, Hastings 4122. Please let me know if you have any questions or need added support.

**Client Information**

Name

Address

Phone Home Mobile

 Work

Email

Referred by

**Statistics**

Age Birth Date

Gender Height

Blood Type

Birth Weight (if known) Current Weight

Ideal Weight Weight One Year Ago

Family/Living Situation:

Children (include age):

Occupation:

Exercise/Recreation/Hobbies:

**History**

1. Have you had any vaccinations? Childhood/Travel/Other?
2. Have you lived or travelled outside of New Zealand? If so, when and where?
3. Have you or your family recently experienced any major life changes? If so, please comment:
4. Have you experienced any major losses in life? If so, please comment:
5. How much time have you had to take off work or school in the last year?

□ 0 to 2 days □ 3 to 14 days □ More than 15 days

**Health Concerns**

1. What are your main health concerns? (Describe in detail, including the severity of symptoms):
2. When did you first experience these concerns?
3. How have you dealt with these concerns in the past?
	* Doctors
	* Self-care
4. Have you experienced any success with these approaches?
5. What other health practitioners are you currently seeing? List name, specialty and phone number below.
6. Please list the date and description of any surgical procedures you have had:
7. How often have you taken antibiotics in infancy/childhood?
8. How often have you taken antibiotics as a teen?
9. How often have you taken antibiotics as an adult?
10. List any medicine you are currently taking:
11. List all vitamins, minerals, herbs and nutritional supplements you are taking now:
12. Have any other family members had similar problems (describe)?

**Nutritional Status**

1. Are there any foods that you avoid because of the way they make you feel? If yes, please name the food and the symptom:
2. Do you have symptoms immediately after eating like bloating, gas, sneezing or hives? If so, please explain:
3. Are you aware of any delayed symptoms after eating certain foods such as fatigue, muscle aches, sinus congestion, etc? If so, please explain:
4. Are there foods that you crave? If so, please explain:
5. Describe your diet at the onset of your health concerns:
6. Do you have any known food allergies or sensitivities?
7. Which of the following foods do you consume regularly?

□ Soda □ Diet soda

□ Refined sugar □ Alcohol

□ Fast food □ Gluten (wheat, rye barley)

□ Dairy (milk, cheese, yoghurt) □ Coffee

1. Are you currently on a special diet?

□ Ovo-lacto □ Diabetic

□ Dairy restricted or dairy-free □ Vegetarian

□ Vegan □ Paleo

□ Blood type □ Raw

□ Refined sugar-free □ Gluten-free

□ Other (please describe)

1. What percentage of you meals are home-cooked?

□ 10 □ 20 □ 30 □ 40 □ 50

□ 60 □ 70 □ 80 □ 90 □ 100

1. Is there anything else we should know about your current diet, history or relationship to food?

**Intestinal Status**

1. Bowel Movement Frequency

□ 1-3 times per day

□ More than 3 times per day

□ Not regularly every day

1. Bowel Movement Consistency

□ Soft and well formed □ Thin, long or narrow

□ Often float □ Small and hard

□ Difficult to pass □ Loose but not watery

□ Diarrhoea □ Alternating between hard and loose

1. Bowel Movement Colour

□ Medium brown □ Variable

□ Very dark or black □ Yellow, light brown

□ Greenish □ Chalky coloured

□ Blood is visible □ Greasy, shiny

1. Do you experience intestinal gas? If so, please explain if it is excessive, occasional, odorous, etc:

**Medical Status**

1. Please check any of the following conditions that apply to your history and briefly describe your symptoms, chosen treatment(s), and dates:

□ Cancer □ Heart disease

□ Kidney disease □ Thyroid disease

□ Hepatitis □ Depression

□ Venereal disease □ Asthma

□ Diabetes □ Allergies

□ High blood pressure □ Anaemia

□ High cholesterol □ Chronic yeast infections

□ Other:

**Health Hazards**

1. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminium)?
2. Do odours affect you?
3. Are you or have you been exposed to second-hand smoke?
4. Do you have mercury amalgam fillings?

**Lifestyle History**

1. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time:
2. Have you used or abused alcohol, drugs, medicines, tobacco or caffeine? Do you still?
3. How do you handle stress?
4. Describe you sleep patterns. Can you get to sleep easily? Can you stay asleep? How many hours do you average per night?

**For Women Only**

1. How are/were your menses (periods)? Do/did you have PMS? Painful periods: if so, explain:
2. In the second half of your cycle do you experience any symptoms of breast tenderness, water retention or irritability?
3. Have you experienced any yeast infections or urinary tract infections? Are they regular?
4. Have you/do you still take birth control pills? If so, please list length of time and type:
5. Have you had any problems with conception or pregnancy?
6. Are you taking any hormone replacement therapy or hormonal supportive herbs? If so, please list again here:

**Sexual History**

1. Do you have any concerns or issues with your sexual functioning that you’d like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?
2. Is there anything else about your sexual history that would be helpful for us to know in your health history?

**Mental Health Status**

1. How are your moods in general? Do you experience more than you would like of anxiety? Depression? Anger?
2. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy?
3. At what point in your life did you feel best? Why?

**Other**

1. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.
2. Who in your family or on your health care team will be most supportive of you making dietary change?
3. Please describe any other information you think would be useful in helping to address your health concern(s:
4. What are your health goals and aspirations?
5. Though it may seem odd, please consider why you might want to achieve that for yourself: