NAME……..
Email……**tel#**……
Please complete questions below with the criteria
1 = mild , 2 = moderate, 3 = severe.
Leave blank if do not have symptom

Health Questionnaire

Annie McRae NC Nutritionist
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DIGESTION
Bloating……..
Gas……..
Diarrhoea……
Constipation …….
Heartburn……
Cramps……
Nausea……
Bad Breath ……

JOINTS/MUSCLES
Pains/aches…….
Arthritis……..
Swollen……
Cramps……
Stiffness……..
Twitches…….

HEAD
Headaches.....
Dizziness.....
Insomnia.....
Faintness……

EYES
Watery/itchy.....
Swollen/red…….
Bags under……
Dark Circles……
Blurred vision …….

EARS
Itchy.....
Earaches.....
Ringing in……

RESPIRATORY
Stuffy nose…….
Sinus.....
Hay fever……
Sneezing attacks …….
Excessive mucus.....
Snoring.....
Shortness of breath.....
Wheezing……
Chest congestion……..
Asthma……

MOUTH/THROAT
Chronic coughing.....
Clearing throat……..
Hoarseness sore……..
Mouth ulcers…….
Itching on roof of mouth……

SKIN/HAIR/NAILS
Itchy/,flaky.....
Hot flashes……
Eczema /psoriasis……
Rashes……
Acne.....
Split, weak nails……
Dull/oily hair.....
Hair falling out……..

HEART
High blood pressure….
Low blood pressure…..
Irregular heartbeat……
Rapid pounding ……
Chest pain……..

IMMUNE
Get many colds/flu……..
Sore throat.coughs…….
UTI……
Yeast Infection……..
History of cancer in family……
White marks on fingernails……
Breastfed as a baby……
Antibiotic use……
Slow wound healing……
Tooth decay……..
Had any biopsies…….

HORMONES
Menstrual problems……
PMT……
Menopausal problems……..
Had miscarriage……..
Use birth control pills…..
Lack of sex drive…….
Infertility.....
Prostate problems…….
Other……

MIND
Poor memory……
Poor concentration……..
Confusion.....
Learning disabilities……
Foggy thinking……
Depression.....
Clumsy……..

ENDOCRINE
Lack of energy……..
Difficulty getting up in the morning……
Feel drowsy during day….
Apathy.....
Feel stressed……..
Irritability.....
Anxious……
Cold sweats……..…
Excessive thirst……
Hyperactivity.....
Mood swings .....
Poor attention span…….
Crave sweets ……..
Crave carbs …….
Crave salty foods……
Binge eat……..
Have food allergies…….
Overweight.....
Underweight.....
Water retention……

YOUR MAIN HEALTH CONCERNS
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SUPPLEMENTS

YOUR DIET

Please list what type of food you typically eat. Be specific and detailed as possible.

Breakfast

Lunch

Dinner

Snacks

Drinks