

Health Promotion

CONSULTATION CARD

Name: _____ **Doctor – Name:** _____
Address inc. _____ **Address:** _____
Post Code: _____
Phone No: _____ **Phone No:** _____
Date of Birth: _____ **Referral?** Yes / No
Occupation: _____

Nutrition, Health and Lifestyle Evaluation

Reason for visit: _____

Medical History (Illnesses/Operations): _____

Do you smoke?: Yes/No Quantity: _____

Weekly Alcohol Consumption: _____

Are you on any prescribed medication?: _____

(Please state exactly what the medication is and how much you are required to take each day)

Are you taking any nutritional supplementations, if so please state:

Current Eating Patterns:

(State all snacks, drinks, and sweets, in addition to meals)

BREAKFAST:

LUNCH:

DINNER:

SNACKS

Do you have any known food allergies or intolerances? Please list: _____

How many meals do you eat per day and at what times?: _____

Health Promotion

Please state how many cups, glasses, mugs you consume of the following, per day:

Tea	_____
Coffee	_____
Herbal Tea	_____
Hot Chocolate	_____
Water	_____
Fizzy Drinks	_____
Fruit Juices or Squash	_____
Soup	_____

Do you have any specific dietary considerations?

Vegetarian	_____
Vegan	_____
Gluten Free	_____
Low Fat Diet	_____
Low Cholesterol Diet	_____
Diabetic	_____
Any Other (please specify)	_____

STRESS PROFILE

- Is your energy less than it used to be? _____
- Do you feel guilty when relaxing? _____
- Do you have a persistent need for achievement? _____
- Are you unclear about your goals in life? _____
- Are you especially competitive? _____
- Do you work harder than most people? _____
- Do you easily become angry? _____
- Do you often do two or three tasks immediately? _____
- Do you get impatient if people or things hold you up? _____

GLUCOSE TOLERANCE PROFILE

- Do you need more than 8 hours sleep at night? _____
- Are you rarely wide-awake within 20 minutes of rising? _____
- Do you need sugar containing foods or drinks in the morning to get you going, like tea, coffee, sugar? _____
- Do you have foods containing tea, coffee or sugar, or cigarettes at regular intervals during the day? _____
- Do you often feel drowsy during the day? _____
- Do you get dizzy or irritable if you don't eat often? _____
- Do you avoid exercise due to tiredness? _____
- Do you sweat a lot or get excessively thirsty? _____
- Do you sometimes lose concentration? _____

Symptom Analysis

Name:

Date:

SYMPTOM ANALYSIS

For a comprehensive assessment of nutritional status, please ensure that you tick or underline any of the symptoms that you suffer from, even if these symptoms appear. Ignore any symptoms that you used to suffer from, as this is for a current nutritional status. Some symptoms are repeated but please underline in all cases.

Mouth Ulcer	<u>A</u>	Tender Muscles	<u>B₁</u>	Muscle tremors or cramps	<u>B₅</u>
Poor night vision		Eye pains		Apathy	
Acne		Irritability		Poor circulation	
Frequent colds or infections		Poor concentration		Burning feet or tender heels	
Dry flaky skin		'Prickly' legs		Nausea or vomiting	
Dandruff		Poor memory		Lack of energy	
Thrush or Cystitis		Stomach pains		Exhaustion after light exercise	
Diarrhoea		Constipation		Anxiety or tension	
Weak tooth enamel		Tingling hands			
Sinus problems		Rapid heart beat		Infrequent dream recall	<u>B₆</u>
		Fatigue		Water retention	
Rheumatism or arthritis	<u>D</u>	Confusion		Tingling hands	
Back ache		Depression		Depression or nervousness	
Tooth decay/gum disease		Poor muscle co-ordination		Irritability	
Hair loss		Insomnia		Muscle tremors or cramps	
Excessive sweating		Muscle wasting		Lack of energy	
Muscle cramps or spasms				Flaky skin	
Joint pain or stiffness		Burning or gritty eyes	<u>B₂</u>		
Lack of energy		Sensitivity to bright lights		Poor hair condition	<u>B₁₂</u>
		Sore tongue		Eczema or dermatitis	
Lack of sex drive	<u>E</u>	Cataracts		Mouth over-sensitive to hot or cold	
Exhaustion after light exercise		Dull or oily hair		Irritability	
Easy bruising		Eczema or Dermatitis		Anxiety or tension	
Slow wound healing		Split nails		Lack of energy	
Varicose veins		Cracked lips		Constipation	
Loss of muscle tone		Cracks in corner of mouth		Tender or sore muscles	
Infertility				Pale skin	
		Lack of energy	<u>B₃</u>	Mood changes	
Frequent colds	<u>C</u>	Diarrhoea		Mental slowness	
Lack of energy		Insomnia		Menstrual problems	
Frequent infections		Headaches or migraines		Clumsy and difficulty walking	
Bleeding or tender gums		Poor memory		Tingling/numbness in hands and feet	
Easy bruising		Anxiety or tension			
Nose bleeds		Depression		Eczema	<u>Folic Acid</u>
Slow wound healing		Irritability		Cracked lips	
Red pimples on skin		Bleeding or tender gums		Prematurely greying hair	
Poor circulation		Acne		Anxiety or tension	
Swollen or painful joints		Indigestion		Poor memory	
		Rough skin		Lack of energy	
				Poor appetite	
				Stomach pains	
				Depression	
				Irritability	

Symptom Analysis

Name:

Date:

Anorexia
Nausea
Dry skin
Poor hair condition
Prematurely greying hair
Tender or sore muscles
Poor appetite or nausea
Eczema or Dermatitis

Biotin

Pale skin
Sore tongue
Fatigue or listlessness
Loss of appetite or nausea
Heavy periods or blood loss

Iron

Manganese
Ringing in ears
Muscle twitches
Childhood 'growing' pains
Dizziness or poor sense of balance
Fits or convulsions
Sore knees
Vertigo

Zinc

Poor sense of taste or smell
White marks on more than two
Finger nails
Frequent infections
Stretch marks
Acne or greasy skin
Low fertility
Pale skin
Tendency to depression
Poor appetite
Sore throats
Painful knee and hip joints
Impotency
Frequent colds

Family history of cancer **Selenium**
Signs of premature aging
Cataracts
High blood pressure
Frequent infections

Dry rough skin
Dry eyes
Frequent infections
Poor memory
Loss of hair or dandruff
Excessive thirst
Poor wound healing
PMS or breast pain
Infertility

EFA

Excessive or cold sweats **Chromium**
Dizziness or irritability after 6
Hours without food
Need for frequent meals
Cold hands
Need for excessive sleep or
Drowsiness during the day
Excessive thirst
'Addicted' to sweet foods

Muscle cramps or tremors **Calcium**
Insomnia or nervousness
Joint pain or arthritis
Tooth decay/gum disease
High blood pressure
Brittle nails
Rheumatism

Muscle tremors or spasms **Mag'**
Muscle weakness
Insomnia
High blood pressure
Irregular heart beat
Constipation
Fits or convulsions
Hyperactivity
Depression
PMS
Leg cramps

* Please list any supplements you are currently taking: brand name and quantity:

Malabsorption
Hair loss
Gas and/or bloating
Anaemia
Muscle weakness
Nutrient deficiencies
Diarrhoea/Constipation
Nutrient deficiencies

Diarrhoea/Constipation
Flatulence
Fatigue
Easy bruising
Weight loss
Impotence
Abdominal cramps
Amenorrhoea
Premature aging
Dry skin
Dermatitis, acne, eczema
Irritable bowel syndrome

HCl Deficiency

Weak peeling or cracked finger nails
Bloating/belching after eating
Burning sensation after eating
Constipation
Diarrhoea
Multiple Food allergies
Fatigue
Excessive abdominal gas after eating
Acne problems

* Please list any medication you are currently taking: brand name and quantity: