THE ALLERGY CENTRE HEALTH FOODS & CLINIC

Date

Name…….. Date of Birth …….. Age ……..

Sex ……. Single / Relationship Children: Yes / No How many……

Address……

Home Tel: ……. Work …… Mobile ……

Email address …… How did you hear about us ……

Current occupation……Doctor……

Please circle or mark any problem with a **'C'** for *current* and **'P'** for *past*.

… ADHD
… Arthritis
… Arthrosclerosis
… Asthma / Eczema
… Back problems
… Bad Breath
… Bloating / Wind
… Cancer
… Candida / Thrush
… Chronic Fatigue Syndrome
… Cold Sores
… Constant Tiredness
… Crohns / Ulcerative colitis
… Cystitis
… Depression / Low Mood
… Diabetes
… Diarrhoea / Constipation
… Ear Infections
… Fatty liver / Gallstones
… Fibromyalgia
… Forgetfulness / Memory Loss
… Glandular Fever
… Haemorrhoids / Fissures
… Other not listed _____

… Hay fever
… Headaches / Migraines
… Heart Problem
… High Cholesterol
… High / Low Blood Pressure
… Hypo / Hyperglycemia
… Irritability
… Irritable Bowel Syndrome
… Kidney Stones / Spurs
… Menopausal
… Menstrual Problems
… Over Weight / Under Weight
… PCOS / Fibroids / Endometriosis
… Pimples/Acne
… PMT
… Poor Concentration
… Post Traumatic Stress
… Sinusitis / Post Nasal Drip
… Stomach Cramps / Indigestion
… Tinea
… Tinnitus
… Tonsillitis
… Ulcers

Family history: health of parents, grandparents, brothers, sisters that may have some bearing on your health:

_____

Current medications:

_____

_____

Current supplements:

_____

_____

_____

Sleep: Great Difficulty falling asleep Wake early Toss all night Wake unrefreshed

Other: _____

Perceived stress level: None 1 2 3 4 5 6 7 8 9 Terrible

Exercise patterns:

_____

_____

_____

Smoker: Yes Past Never **Alcohol intake:** Regular Social Rarely Never

Main reason for visit:

_____

_____

I/WE HEREBY ACKNOWLEDGE THE TEST BEING UNDERTAKEN IS AN INDICATOR TEST ONLY AND NOT A MEDICAL DIAGNOSIS.

Please sign …… Date / /