Birth to Pre-teen Health Appraisal Questionnaire

DIGESTIVE SYSTEM (PLEASE TICK ONLY ONE BOX PER LINE)	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Excessive belching, burping	✔		
Bloating (feeling off heaviness, fullness in stomach region)	✔		
Bad breath	✔		
History of anaemia/low iron	✔		
Indigestion with particular foods	✔		
Heartburn	✔		
Constipation	✔		
Vomiting	✔		
Excessive wind/gas	✔		
Diarrhea	✔		
Alternating constipation/diarrhea	✔		
Undigested food in stool	✔		
Mucus in stool	✔		
Blood in stool	✔		
Haemorrhoids/anal fissures	✔		
Anal itching	✔		
Fatigue	✔		
Fluid retention	✔		
Suffer from gum disease / gingivitis	✔		
Amalgam fillings			✔
Dental implants	✔		

CARDIOVASCULAR SYSTEM	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Excessive fatigue (feeling tired most of the time)	✔		
Feeling worse after exercise	✔		
Dizzy spills	✔		
Yellow of eyes or skin	✔		
Red sore tongue	✔		
Swelling of feet/ankles	✔		
Need coffee, tea, choc as pick me ups	✔		
Intolerance to cold	✔		
Swelling/tightness in front of neck	✔		
Weight gain	✔		
Poor memory	✔		
Feeling hot, sweaty	✔		
Insomnia	✔		
Irritable/over-sensitive	✔		
Low mood, mood swings	✔		
Memory problems	✔		
Fluid retention	✔		

Birth to Pre-teen Health Appraisal Questionnaire

IMMUNE SYSTEM	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Nasal congestion	✔		
Hay fever	✔		
Cough with mucus	✔		
Dry cough	✔		
Cold sores	✔		
Swelling in groin/neck/armpit	✔		
Wounds heal slowly	✔		
Excessive loss of hair, thinning of body or facial hair or slow hair growth	✔		
Headaches	✔		
Sensitive to light			
Dark circles under eyes			
Itching all over the body			
Rash/eczema			
Incontinence			
Burning sensation upon urination			
Athlete's foot			

MOOD AND SKIN	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Acne			
Oily skin			
Dry skin			
Feeling depressed, teary or sensitive			
Feeling aggressive, anxious, on edge , irritable or easily angered			
Feeling suicidal, having thoughts of self harm or suicide			
Feeling the urge to harm others			
Mood swings, irritability, depression, nervousness, anxiety			
Clumsiness			
Headaches or dizziness			
Difficulty concentrating, poor memory or confusion			
Memory, or confusion			
Headaches or migraines			
Food cravings or binge eating			

Birth to Pre-teen Health Appraisal Questionnaire

TOXIC EXPOSURE IN THE HOME	NO, NEVER	YES, PREVIOUSLY	YES, CURRENTLY
Mould growth			✔
Water filter used			✔
Skincare brand(s)			
Use of aluminium in the kitchen re pots / pans and or foil	✔		
Home cleaning product brand(s) *(answer here)*			
Where is the wifi portal located? *(answer here)*			
Do you consume organic produce, if so specify please *(answer here)*			

GENERAL HEALTH HISTORY

Please list any medications you have taken in the last 6 months & what you are currently taking.

DRUG NAME	DOSAGE	THE DATE IN WHICH YOU STARTED YOUR TREATMENT

List of any other over-the-counter herbal, vitamin or homeopathic supplements you are taking.

ALL (OVER THE COUNTER) SUPPLEMENTS / HOMEOPATHICS	DOSAGE	THE DATE IN WHICH YOU STARTED YOUR TREATMENT

Birth to Pre-teen Health Appraisal Questionnaire

GENERAL HEALTH HISTORY

Please list any surgeries you have had in the past, please insert the year of the surgery:

Please list your current health concerns that we will be addressing:

List any family history of diseases on both sides of the family:

List any other relative comments:

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Thank you for taking out the time to acknowledge the challenges that you are currently experiencing and be ready to actively make changes that will enhance your physical, mental and emotional wellness. Get ready to be blown away by the power of change that you have allowed yourself to experience. You are worth it.