Karen Featherstone, Clinical Nutritionist
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Give Me Life
Supporting Life Naturally

Here, at Give Me Life, I take a holistic approach to health. It's important that I develop a clear picture of your physical, bio-chemical and emotional health, both currently and historically so I can create a personalised approach to support you on your journey back to good health.

Please fill out this form with **as much** information as you can before you come for you first consultation. This will allow us to spend more time together, creating a safe and effective treatment plan for you.

YOUR PERSONAL INFORMATION

Name: _____

Address: _____

Phone: (h) _____ (c) _____

Email: _____

DOB: _____ Age: _____ Gender: Male Female

Relationship Status: _____ Children (Ages): _____

Occupation: _____ Since When: _____

Emergency Contact: _____ Phone: _____

General Practitioner: _____ Phone: _____

Do you give permission for me to contact your general practitioner if necessary (circle): Yes No

Do you have any specific beliefs (spiritual/religious/cultural) or requirements that I need to incorporate into your consultations/treatment programme. E.g. vegetarian, kosher food, avoid touching my head:

_____

_____

CHIEF HEALTH CONCERN:

Please provide a brief outline of your chief health concern and rate it's severity on a scale of 1 – 10 *(10 being most severe)*.

_____

_____ Scale (1-10): _____

When did this start? _____

Was there anything significant happening in your life before or at the onset of this condition?

_____

What do you think may have contributed to or caused this condition?

_____

What makes this condition worse? E.g. stress, particular foods, heat, etc.:

_____

How much does this condition affect your daily life (scale of 1 – 10; *10 being completely debilitated*): _____

Have you had an official diagnosis from another healthcare practitioner? If yes, provide the practitioners name and what tests were performed to result in a diagnosis:

_____

_____

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Other Health Concerns:

Please list any other health concerns and rate their severity (on a scale of 1 – 10, *10 being most severe*)

1. _____ Scale (1-10): ____
2. _____ Scale (1-10): ____
3. _____ Scale (1-10): ____

Personal Health Goals:

Rate how willing you are on a scale of 5 (very willing) to 1 (not willing to):

____ Modify your diet

____ Take supplements each day

____ Keep a food diary periodically

____ Adjust your lifestyle *(E.g. work demands, sleep habits)*

____ Practice a relaxation technique

____ Engage in regular exercise

What would you like to achieve as a result of working with me?

Your Current Lifestyle:

Please comment on the various aspects of your current lifestyle:

Other than the health conditions mentioned above how is your overall health *(1 = very poor, 10 = Fantastic):*

Sleep (usual bed and wake time, broken sleep, etc.):

Exercise (type and frequency):

Relaxation (type and frequency):

General Stress on a scale of 1 – 10 *(10 = I can't cope any more)* and causes, E.g. family/work/relationship:

Relationships (supportive relationships - friends, family, intimate):

Social activities and hobbies:

Spiritual/cultural activities:

Holidays (frequency and type):

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YOUR CURRENT LIFESTYLE CONTINUED ...

Indicate your current emotional wellbeing on a scale of 1 – 10 *(1 = I am not coping at all, 10 = Fantastic):* _____

Indicate your general energy levels on a scale of 1 – 10 *(1 = no energy, 10 = Unlimited energy)*: _____

Peak energy times: _____ Low energy times: _____

List any medications you are current taking: _____

List any supplements you are currently taking: _____

Do you currently suffer with allergies? If yes, what and how long: _____

Food sensitivities: Casein Corn Dairy Egg Gluten Peanuts Shellfish Soy Wheat Other

If other, please explain: _____

Do you currently live, or have you ever lived in a damp or mouldy home, if yes, how long?

Alcohol intake (type and frequency):

Recreational drug use (type and frequency): _____

Do you currently smoke? If yes, amount or frequency: _____

Life changing events (births, deaths, marriages, divorces, moves, other traumatic events) and dates:

CHEMICAL & ELECTROMAGNETIC EXPOSURE

Personal Care & Household Products (please indicate products used and brands):

Personal care:	**Household Products:**	**Electromagnetic (Hours per day):**
Perfume/cologne:	Dish wash liquid:	Watching TV:
Hand/body lotion:	Air freshener:	Computer use:
Nail polish:	Fly spray:	On a landline:
Nail polish remover:	Paint:	On a mobile phone:
Shaving cream:	Laundry powder:	Wearing a pager:
Shampoo:	Glass cleaner:	Wearing a headset:
Conditioner:	All-purpose cleaner:	Wearing a watch:
Hair spray	Toilet cleaner:	Wearing hearing aids:
Other hair products:	Bleach:	Travelling by vehicle:
Hair dye:	Fertilisers:	Using a microwave:
Deodorant:	Pesticides:	**Do you use any of the following:**
Toothpaste:	Insecticides:	Electric blanket:
Make-up:	Herbicides:	Water bed:
Moisturiser:	Pesticides:	Electric or gas stove:
Cleanser:	Other:	Electric or gas heater:
Soap:	Other:	Dehumidifier:
Other:	Other:	

When you sleep, is your head within 3 metres of a plug-in clock? Yes No

Do you use either a water purifier and/or a shower filter? Yes No

What type of cookware do you use: Stainless steel Teflon-coated Aluminium Cast iron Glass Silicone Other

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Dental Health

Do you have any dental concerns? _____

When was your last dentist appointment and what treatments were performed: _____

Do you currently have or have you ever had amalgam/silver fillings? _____

If you have had amalgam/silver fillings removed, when? _____

Do either of your parents have amalgam/silver fillings? _____

Health History:

How was your health during childhood and adolescence on a scale of 1 – 10 *(1 = very poor, 10 = fantastic)*:

Have you ever had any significant accidents: _____

Have you ever been hospitalised? If yes, why? _____

Have you ever suffered from allergies in the past? If yes, what and how long: _____

List any medications you used extensively in the past: _____

Have you ever been exposed to specific chemicals, toxins or sprays in the past? _____

What vaccinations have you had as a child or adult? _____

What countries have you travelled to in the past five years? _____

Indicate your emotional well-being whilst growing up on a scale of 1 – 10 *(1 = Poor, 10 = Fantastic):* _____

Family Health History

Please provide details of any physical or emotional illnesses members of your family have experienced:

Mother:	Father:	Siblings:	Children:

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Body System Review

Please tick the following boxes if you have experienced this symptom in the past month.

Digestive System

- ☐ Discomfort or pain after eating
- ☐ Cramping after eating
- ☐ Bloating after eating or as the day progresses
- ☐ Flatulence
- ☐ Heartburn or acid reflux
- ☐ Excessive fullness after eating
- ☐ Nausea or vomiting *(with no known cause)*
- ☐ Constipation
- ☐ Diarrhoea after food
- ☐ Diarrhoea (*chronic*)
- ☐ Feels like you never fully evacuate
- ☐ Undigested food in stools
- ☐ Mucous in stools
- ☐ Blood in stools
- ☐ Black or tarry looking stools
- ☐ Green stools
- ☐ Floating stools
- ☐ Stools stick to sides of toilet bowl
- ☐ Odorous stools
- ☐ Bad breath
- ☐ Strong body odour
- ☐ Diagnosed with Irritable Bowel Syndrome
- ☐ Diagnosed with Crohn's disease
- ☐ Diagnosed with Inflammatory Bowel Disease

Integumentary System (Skin)

- ☐ Facial acne (*chronic*)
- ☐ Facial acne (*cyclically*)
- ☐ Acne on body
- ☐ Eczema
- ☐ Dermatitis
- ☐ Psoriasis
- ☐ Excessively dry or flaking skin
- ☐ Excessively oily skin
- ☐ Itchy skin
- ☐ Cracked skin
- ☐ Weepy skin
- ☐ Hives
- ☐ Boils, sores and cysts
- ☐ Excessive sweating

Respiratory System

- ☐ Diagnosed asthma
- ☐ Diagnosed hay fever
- ☐ Shortness of breath
- ☐ Tightness or constriction in chest
- ☐ Chest pain
- ☐ Excessive coughing
- ☐ Wheezing
- ☐ Mucous in throat/chest
- ☐ Blood in mucous

Urinary System

- ☐ Urinary Tract Infections (*frequently in the past*)
- ☐ Kidney infection(s) in the past
- ☐ Burning or pain during urination
- ☐ Strong smelling urine
- ☐ Cloudy urine
- ☐ Blood in urine
- ☐ Poor urine flow
- ☐ Lower back or pelvic pain
- ☐ Incontinence
- ☐ Waking at night to urinate

Musculoskeletal System

- ☐ Aching muscles (*day or night*)
- ☐ Cramping in muscles (*day or night*)
- ☐ Restless legs (*twitching in legs at night*)
- ☐ Muscle weakness
- ☐ Joint swelling or inflammation
- ☐ Joint stiffness
- ☐ Joint pain
- ☐ Tendonitis (diagnosed)
- ☐ Arthritis (diagnosed)
- ☐ Repetitive strain injury (diagnosed)

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Body System Review Continued …

Cardiovascular System

- ☐ Diagnosed anaemia (*now or in the past*)
- ☐ Bruise easily
- ☐ Pale complexion
- ☐ Shortness of breath
- ☐ Dizzy upon standing or when walking up stairs
- ☐ Unusual muscle weakness
- ☐ Fatigue
- ☐ High blood pressure (*diagnosed*)
- ☐ Low blood pressure (*diagnosed*)
- ☐ High cholesterol (diagnosed)
- ☐ Heart palpations
- ☐ Irregular heart beat
- ☐ Chest pain
- ☐ Cold extremities (*hands and feet*)
- ☐ Discoloured hands or feet (*bluish/purple/blotchy*)
- ☐ Broken capillaries
- ☐ Varicose veins
- ☐ Burst blood vessels
- ☐ Hemorrhages (*in past*)
- ☐ Sighs frequently
- ☐ Feel like you need air (*always opening windows*)
- ☐ Ankles swell frequently
- ☐ Cough at night
- ☐ Reddened complexion
- ☐ Frequent infections
- ☐ Afternoon headaches

Lymphatic/Immune System

- ☐ Swollen gland (*regularly*)
- ☐ Frequent colds/flu
- ☐ Frequent infection
- ☐ Hay fever
- ☐ Mucous cough
- ☐ Sinusitis
- ☐ Blocked/runny/congested nose
- ☐ Itchy eyes/throat
- ☐ Cold sores
- ☐ Ear infections
- ☐ Dermatitis
- ☐ Itchy skin
- ☐ Food allergies
- ☐ Food sensitivities/intolerances
- ☐ Glandular fever (*in the past; diagnosed*)
- ☐ Tonsillitis (*in the past; diagnosed*)
- ☐ Tonsils removed (*in the past*)
- ☐ Epstein Barr Virus (*diagnosed*)
- ☐ Hepatitis (*in the past; diagnosed*)
- ☐ Shingles (*in the past; diagnosed*)
- ☐ Pneumonia (*in the past; diagnosed*)
- ☐ Chronic fatigue syndrome
- ☐ Autoimmune disease
- ☐ Yearly flu vaccine

Nervous System

- ☐ Headaches
- ☐ Migraines
- ☐ Insomnia
- ☐ Depression
- ☐ Anxiety or nervousness
- ☐ Irritability
- ☐ Clench or grind teeth
- ☐ Mouth ulcers
- ☐ Hearing, taste, smell, vision problems
- ☐ Calm on the outside, troubled on the inside
- ☐ Driving need to get things right
- ☐ Nervous tic

Reproductive System (Men)

- ☐ Sexually transmitted diseases *(now or in the past)*
- ☐ Penal pain
- ☐ Penal discharge
- ☐ Blood in urine
- ☐ Low testosterone (diagnosed)
- ☐ Unexplained muscle loss
- ☐ Low energy
- ☐ Low libido
- ☐ Decreased strength
- ☐ Enlarged prostate (diagnosed)
- ☐ Difficulty urinating
- ☐ Interrupted urine flow
- ☐ Pain or burning with urination
- ☐ Waking at night to urinate

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Body System Review Continued …

Reproductive System (Women)

- ☐ Sexually transmitted diseases *(now or in the past)*
- ☐ Pregnancy or pregnancies
- ☐ Difficult with birth
- ☐ Difficulty conceiving
- ☐ Miscarriage(s)
- ☐ Cyclic mood swings
- ☐ Retaining fluid around menstruation
- ☐ Weight gain around menstruation
- ☐ Hormonal headaches/migraines
- ☐ Food cravings before or during menses
- ☐ Painful abdomen before or during menses
- ☐ Painful lower back before or during menses
- ☐ Tender breasts before or during menses
- ☐ Excessive menstrual flow
- ☐ Irregular menstruation
- ☐ Excessive facial/body hair
- ☐ Hot flushes/sweats
- ☐ Night sweats
- ☐ Vaginal dryness
- ☐ Vaginal atrophy (thinning vaginal skin)
- ☐ Unusual vaginal discharge
- ☐ Unusual vaginal odour
- ☐ Painful during intercourse
- ☐ Thrush
- ☐ Endometriosis (*diagnosed)*
- ☐ Uterine fibroids (*diagnosed)*
- ☐ *Breast fibroids* (*diagnosed)*
- ☐ Uterine polyps (*diagnosed)*
- ☐ Poly Cystic Ovarian Syndrome (*diagnosed)*
- ☐ Primary unexplained infertility
- ☐ Secondary unexplained infertility

Endocrine System

- ☐ Fatigue
- ☐ Anxiety
- ☐ Depression
- ☐ Poor concentration
- ☐ Foggy brain
- ☐ Tired upon waking
- ☐ Energy only in the evenings
- ☐ Insomnia
- ☐ Low BP (*diagnosed*)
- ☐ Rapid heart beat
- ☐ Light headed upon standing
- ☐ Craves salt
- ☐ Afternoon headaches
- ☐ Weakened immune function
- ☐ Loose bowel motions
- ☐ Constipation
- ☐ Excessive sweating
- ☐ Cold hands and feet
- ☐ Cold all the time
- ☐ Dry skin
- ☐ Dry hair
- ☐ Brittle nails
- ☐ Increased thirst
- ☐ Increased hunger
- ☐ Dry mouth
- ☐ Frequent urination
- ☐ Sweet smelling urine
- ☐ Blurry vision
- ☐ Irritability
- ☐ Trembling
- ☐ Heart palpations
- ☐ Dry/itching skin
- ☐ Yeast/fungal infections
- ☐ Numb, tingling feet
- ☐ Slow healing sores
- ☐ Craves sweet foods
- ☐ Craves caffeine
- ☐ Frequent infections
- ☐ Hyperthyroidism (*diagnosed*)
- ☐ Hypothyroidism (*diagnosed*)
- ☐ Adrenal fatigue
- ☐ Blood glucose imbalances
- ☐ Pre-diabetic *(diagnosed)*
- ☐ Type I Diabetes *(diagnosed)*
- ☐ Type II Diabetes *(diagnosed)*

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Body System Review Continued …

Emotional Tendencies	
☐ Feel satisfied with life	☐ Feel dissatisfied/discontent with life
☐ Generally happy and content	☐ Regularly feel angry/frustrated
☐ Feels able to make change if unhappy	☐ Regularly feel sad/low/depressed
☐ Copes well with day to day living	☐ Regularly feel lonely
☐ Feels supported	☐ Grieving
	☐ Feels unable to make change if unhappy
	☐ Feels unsupported

Thank you for taking the time to fill this form out.

Please return this form, along with your food and Eliminations diaries, to me at least 24-hours prior to you coming for your initial appointment. You can do this by scanning and emailing the forms back to me, or by leaving your forms in an envelope with the staff at The Lotus Heart.