

SYMPTOM ANALYSIS

The symptoms listed below are often associated with nutritional deficiency. Please UNDERLINE any conditions you are presently aware of.

<p>GENERAL Headache / Migraines Fever / Chills Fainting Dizziness Convulsions Loss of sleep Fatigue Nervousness Weight loss / gain Numbness / pain in arms / legs General aches and pains Allergy Food sensitivities Wheezing</p> <p>EARS, NOSE AND THROAT Frequent colds Frequent infections Flu Earache / ear noises Ear discharge Nose bleeds Nasal obstruction Sore throat / hoarseness Asthma Gum trouble Deafness Enlarged thyroid Tonsillitis Sinus infection Enlarged glands Hay fever</p> <p>SKIN Acne Candida Skin eruptions Itching Fungal infections Bruise easily Dry / rough skin Greasy skin Boils Sensitive skin Pale skin Eczema Shingles Dandruff Psoriasis Mouth ulcers Stretch marks Varicose veins Dermatitis Red pimples Slow wound healing</p> <p>ENERGY LEVELS Lack of energy Exhaustion after light exercise ME Apathy Insomnia Fatigue Hyperactivity Need for excessive sleep or drowsiness during the day</p>	<p>CARDIOVASCULAR Irregular / rapid heartbeat Blood Pressure High / Low Pain over heart Previous heart attack Hardening of arteries Swelling of ankles Poor circulation Paralytic stroke Blood clots High Cholesterol</p> <p>MUSCULOSKELETAL Stiff neck Backache Shoulder trouble Painful elbow Wrist trouble Knee problems Swollen joints Muscle weakness Joint pain or stiffness Loss of muscle tone Arthritis Tender or sore muscles Sciatica Muscle tremors or spasms Rheumatism Osteoarthritis Arthritis</p> <p>GENITOURINARY Frequent urination Painful urination Urine discoloration Blood in urine Excessive thirst Kidney infection or stones Bed wetting Water retention Thrush Cystitis Inability to control urine Prostate concerns</p> <p>GASTROINTESTINAL Poor appetite Poor sense of taste or smell Difficult digestion Belching / gas / flatulence Nausea / Vomiting Heartburn Vomiting blood Need for frequent meals Poor appetite Stomach pains Constipation Diarrhoea Irritable Bowel syndrome Haemorrhoid (piles) Intestinal worms Liver trouble Gall bladder trouble Jaundice Colitis / Crohns disease Celiac disease (gluten intolerance)</p>	<p>RESPIRATORY Chronic cough Dry chesty cough Spitting up phlegm Spitting up blood Chest pain Asthma</p> <p>MENTAL / EMOTIONAL Nervousness Depression Anxiety or tension Poor memory /concentration Irritability Grinding teeth Schizophrenia Adrenal burnout</p> <p>ACCESSORY ORGANS Loss of hair Dandruff Dry /course hair Dull or oily hair Poor hair condition Split nails Hair loss White marks on more than two finger nails</p> <p>REPRODUCTION Infertility Lack of sex drive</p> <p>WOMEN ONLY PMS Breast pain Bloating Water retention Heavy periods or blood loss Painful menstrual problems Hot flushes Irregular cycle Cramps or backache Previous miscarriage Vaginal discharge Lumps in breast Menopausal problems</p> <p>OTHER, PLEASE LIST _____ _____</p> <p>Do you have a history of using Antibiotics, Antidepressants, Oral Contraceptive Pill, or other medication? Yes/No If yes, please circle and give details: _____ _____ _____</p> <p>Have you had any vaccinations? Yes/No (Including travel/child vaccinations) Yes/No Please list if you can remember: _____ _____</p>
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PLEASE **TICK BY** ANY STATEMENTS YOU ARE PRESENTLY AWARE OF.

Exercise

- Do you take exercise that noticeably raises your heartbeat for 20 minutes more than 3 times a week?
- Does your job involve vigorous activity?
- Do you regularly play a sport (football, squash etc)?
- Do you have any physically tiring hobbies (gardening, etc.)?
- Do you consider yourself fit?

Pollution

- Do you live in a city or by a busy road?
- Do you spend more than 2 hours a week in traffic?
- Do you exercise (job, cycle, play sports) by busy roads?
- Do you smoke more than 5 cigarettes a day?
- Do you buy foods exposed to exhaust fumes?
- Do you generally eat non-organic produce?
- Do you drink more than 1 unit of alcohol a day?
- Do you spend a lot of time in front of a TV or computer?
- Do you usually drink unfiltered tap water?

Digestion

- Do you chew your food thoroughly?
- Do you sometimes suffer from bad breath?
- Are you prone to stomach upsets?
- Do you often get a burning sensation in your stomach?
- Do you find it difficult digesting fatty foods?
- Do you occasionally use indigestion tablets?
- Do you suffer from flatulence or bloating?
- Do you experience anal irritation?
- Do you have a bowel movement daily?
- Do your stools float?

Glucose Tolerance

- Do you need more than 8 hours sleep a night?
- Are you rarely wide-awake within 20 minutes of rising?
- Is your energy less now than it used to be?
- Do you have tea, coffee, sugary foods or drinks, 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?
- Do you need something to get you going in the morning, like a tea, coffee or cigarette?

Cardiovascular

- Is your blood pressure above 140/90?
- Is your pulse after 15 minutes rest above 75?
- Are you more than 14lbs (7kg) over your ideal weight?
- Do you smoke more than 5 cigarettes a day?
- Do you do less than 2 hours exercise a week?
- Do you eat more than one spoon of sugar a day?
- Do you eat meat more than 5 times a week?
- Do you usually add salt to your food?
- Do you have more than 2 alcoholic drinks a day?
- Is there a history of heart disease in your family?

Immune

- Do you get more than three colds a year?
- Do you find it hard to shift an infection (cold or otherwise)?
- Are you prone to thrush or cystitis?
- Do you often take antibiotics more than twice a year?
- Is there a history of cancer in your family?
- Have you ever had any biopsies for growths or lumps?
- Do you have an inflammatory disease such as eczema, asthma or arthritis?
- Do you suffer from hay fever?
- Do you suffer from allergy problems?

Allergy

- Do you suffer from any of the following? Please underline:
Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloating, facial puffiness.
- Do you have any allergies? If so what?

State type of reaction

Have you been tested?

Women Only

- Are you pregnant? If so how many weeks? _____
- Are you trying to become pregnant? _____
- Have you ever had a miscarriage? _____
- Do you have an IUD fitted, or use the birth control pill?

State which:

- Are your periods regular? _____
- Are you post-menopausal? _____
- Do you suffer from any pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, headaches (please underline)

Men Only

- Prostate problems
- Waking regularly to urinate at night
- Difficult to start & stop urine stream
- Decreased sexual function
- Pain or burning sensation when urinating

Do you suffer from any of the following?

- Diabetes
- Epilepsy
- Anaemia
- Thyroidism
- Cancer
- Heart disease
- Hepatitis
- Alcoholism
- Anorexia / bulimia
- AIDS
- Candida
- Addictions
- Adrenal burnout

YOUR FOOD DIARY

Write down all the foods and drinks consumed over the next two days, starting today. Please add information such as quantities eaten, brand names, whether the food is fresh

DAY 1: Please note any particular feelings/symptoms associated with your intake of food.
Breakfast
Lunch
Dinner
Snacks & Drinks

DAY 2: Please note any particular feelings/symptoms associated with your intake of food.
Breakfast
Lunch
Dinner
Snacks & Drinks

Your Food Preferences

Do you avoid any foods for cultural/ethical/health reasons? Please list:

Do you suspect that any foods 'don't agree with you'? Please list:

DAY 3: Please note any particular feelings/symptoms associated with your intake of food.
Breakfast
Lunch
Dinner
Snacks & Drinks

YOUR EATING HABITS

Please tick the questions to which you would answer yes or fill in the number of times you eat the food mentioned in the question.

- Were you breast-fed?
- Do you cook your own food?
- Do you microwave your food?
- Do you steam your vegetables?
- What percentage of your food is organic?
- How many teaspoons of sugar do you add to food / drinks each day?
- Do you use salt in your cooking or to your food?
- How many coffees / tea do you drink each day?
- How many times a week do you have meals containing fried food?
- How many packets of 'processed' or fast foods do you eat each week?
- How many times a week do you eat chocolate or confectionery?
- What percentage of your diet is raw fruit and raw vegetables?
- Do you normally eat white rice or flour?
- How many slices of bread or rolls do you eat each week?
- How many pints of milk do you drink a week?
- How many times a week do you eat red meat? (beef, pork, lamb or game)
- How many times a week do you eat white meat? (poultry, fish)
- What is your usual alcoholic drink? How many glasses a week?
- How many times a week do you eat live yoghurt?
- Do you use a water filter or drink bottled water instead of tap water?
- Do you frequently eat under stressful conditions or on the move?

Please list any dietary or herbal supplements you are taking:

Terms of Engagement

1. A Nutrition Questionnaire will be sent to you after booking a consultation. Once completed, this must arrive at Balance Nutritional Therapy at least 24 hrs before to your initial visit. If the questionnaire is not returned in due time, the consultation may be postponed.
2. Maya Rowson's advice and guidance, including the supplement programme, will depend on the information provided in the questionnaire and during the consultation. No responsibility can be accepted in cases where diagnosed medical conditions have been omitted or medication details have not been fully disclosed initially or when changed by your doctor whilst following your nutritional programme. Likewise, it is your responsibility to keep your doctor up to date about the nutritional strategy you have been provided with.
3. The aim of nutritional intervention is to facilitate the body's own biochemical re-balancing and self-healing in an attempt to alleviate distressing symptoms. Nutritional advice is not a substitute for professional medical diagnosis, advice and/or treatment.
4. Whilst the benefit achievable from Nutritional Therapy varies between individuals, the success of the treatment will depend on your compliance with the advice provided. No responsibility can be accepted in the case of non-compliance, altering of recommendations by a third party or if the supplement programme is continued beyond the period of time specified at the time of receiving the nutritional guidance.
5. Fees for each visit will be payable at the end of each consultation.
6. Cancellations of consultations must be made at least 24 hours prior to the time of the consultation, or fee may be charged.
7. By signing the declaration at the end of the Nutrition Questionnaire you indicate that you understand and agree to be bound by the above Terms & Conditions.

Data Protection

In order to be able to assess and advise you a Questionnaire must be completed. This and other information is private and confidential and we take every measure to keep such information secure. Our policy is not to disclose it to any third party without your written consent. Returning this form duly signed constitutes your express consent to the processing of such data.

I understand the above, and agree that our professional relationship will be based on the content of this document.

Signed by client:Date.....

Signed by Nutritional Therapist:Date.....

Maya Rowson N.H.F. Dip, BA (Hons,) MBANT

Please return this form by post at least 1 days before your consultation to: Maya Rowson, Upper Steanbridge Mill, Steanbridge Lane, Slad, Gloucestershire, GL6 7QE.