Health Profile Form

Kindly complete this form and email it back to the student practitioner, at least 72hrs before the booked session. This allows time to look through your completed form before the session, in this way we get the most out of the session. As this is a **School Clinic we require a minimum of THREE sessions** so the student practitioner can provide the best service, follow your progress which is all under supervision and learn from your progress. The same student practitioner will be taking your case all the way through. You will have already received an email with the payment link, if not do email **hello@newschoolofnutrition.com** so we can ensure this is all received and completed. We look forward to supporting you on your health journey. By signing this form you are committing to a minimum THREE School clinic sessions which must be booked over a 3-4 month period.

This is a pretty detailed health profile form, so take your time and provide as much information as you feel comfortable. As you complete the form, you may also notice certain feelings coming up, certain 'aha moments', this is all part of the healing process, and in some cases the therapeutic process starts as soon as you start filling in the form. Just take your time and we look forward to working with you.

Thank you for booking with the New School of Nutrition Clinic!

1. FULL NAME

2. Email address

3. DATE OF BIRTH

Example: January 7, 2019

Height:

Weight:

4. GENDER. Tick answer

☐ Female ☐ Male ☐ Other

5. FULL Postal Address incl. Post Code/Zip Code, Country of residence.

6. Phone Number (include country code)

7. Contact Details of GP/Primary Health Care Physician: Address and Phone number

8. Do you give consent for me to contact your GP, if necessary? Tick answer

☐ YES ☐ NO

9. Referred by? family / friend / G.P/ advert / social media / other – please specify

10. Describe the condition(s) about which you are seeking help for, also providing your health goals

11. Are you having any other treatment for the above condition(s)?

12. List all the medications including vitamins, supplements, and any long-term prescriptions such as birth control pill, blood pressure tablets, HRT, tranquilizers, sleeping pills, pain killers etc……This is very important so we can research your medications and understand their impact on nutrients, side effects, etc. And ensure we do not prescribe any supplements that may be contra-indicated.

13. Have you received any other 'alternative' treatments for any previous health issues that have helped in the past?

14. MEDICAL HISTORY: List all major diseases, accidents, hospitalizations, medical treatments and traumas in CHRONOLOGICAL order. Please include childhood diseases, dental work etc. This is very important, as can help look at vital connections between current health and past history. Any body parts removed such as gallbladder?

15. VACCINATIONS: List all vaccinations and any reactions, including any travel vaccinations with dates where possible.

16. FAMILY MEDICAL HISTORY List all diseases of blood relations, including cause and age of death where applicable. Please indicate also where there may be a history of alcoholism, drug addiction, behavioural problems, birth defects, disabilities, or any other unusual condition or imbalance such as allergies, hay fever, asthma, etc..PATERNAL GRANDPARENTS, MATERNAL GRANDPARENTS, MOTHER, FATHER, SIBLINGS, CHILDREN

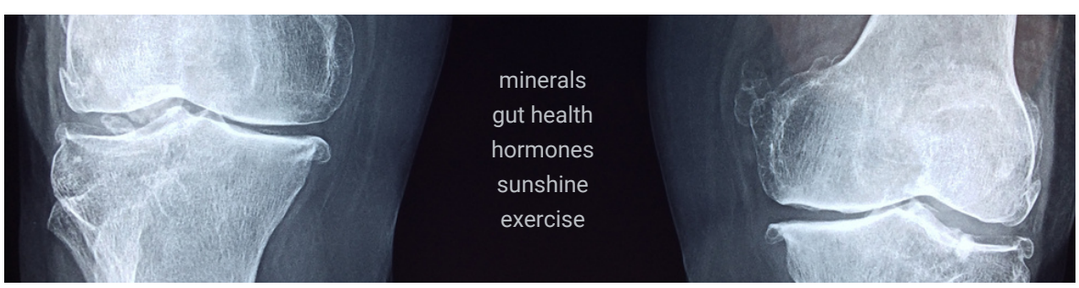
17. ALLERGIES: list all allergies, past and/or present (such as any medications, hay fever, cats, etc.) If so, do you take any medications to alleviate these allergies.

18. CARDIOVASCULAR: Select any of the below that refer to you currently with regular frequency.

Check all that apply.

- [ ] Fatigue
- [ ] Numbness of hand and feet
- [ ] Noises in head or ringing in ear
- [ ] Drowsy
- [ ] Palpitations
- [ ] Sigh frequently, air hunger
- [ ] Increased need for fresh air
- [ ] Swollen ankle(s) worse at night
- [ ] Tendency to anemia
- [ ] Smoker
- [ ] Shortness of breath
- [ ] Swelling of legs and ankles
- [ ] Light-headedness
- [ ] Loss of consciousness
- [ ] Little or no joy in life
- [ ] Experiencing loss
- [ ] Experiencing rejection
- [ ] Obesity
- [ ] High C-reactive protein
- [ ] Little or no exercise
- [ ] Chest pain
- [ ] Fatigue/ pain in arms/ legs
- [ ] Feeling unloved Impatience
- [ ] Feeling rejected
- [ ] None of the above

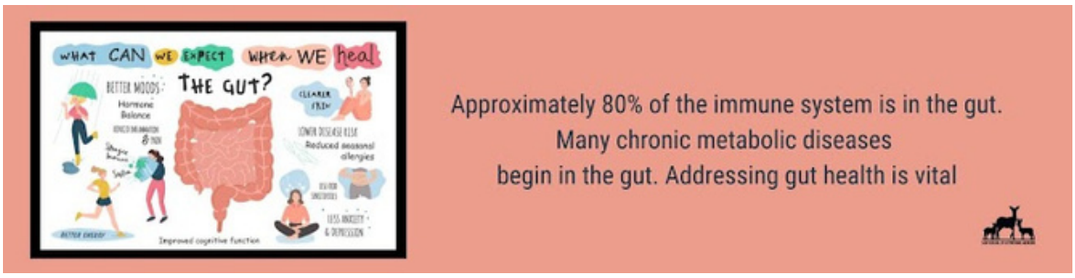
19. BONES and MINERALS: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

- [ ] Hip and joint pain
- [ ] Receding gums and/or dental cavities
- [ ] Tendency towards slouching
- [ ] Bone loss/ osteoporosis
- [ ] Crunching or creaking joints
- [ ] None of the above

20. DIGESTION: Select any of the below that refer to you currently with regular frequency.

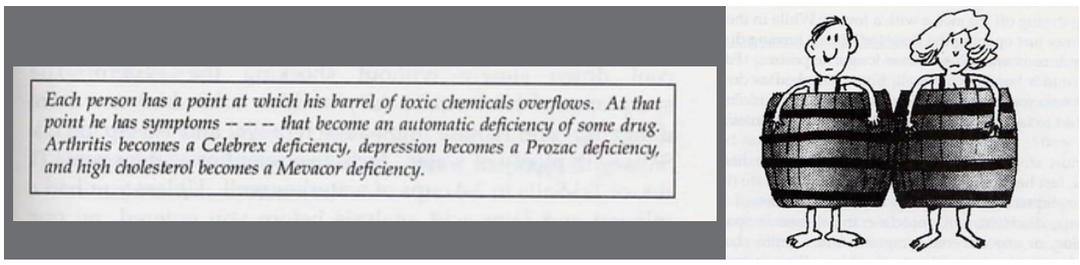


Check all that apply.

- [ ] Lower bowel gas several hours after eating
- [ ] Burning stomach sensation relieved by eating
- [ ] Alternating diarrhea/constipation
- [ ] Indigestion
- [ ] Difficult bowel movements
- [ ] Ulcers/ colitis/ gastritis/ IBS
- [ ] Bloating
- [ ] Bad breath
- [ ] Coated tongue
- [ ] Rectal itching
- [ ] Inability to gain weight
- [ ] International travel
- [ ] Cramping
- [ ] Excessive belching/ burping
- [ ] None of the above

21. This section is ONLY if you have submitted a gut test, such as a GI MAP test or a GI ECOLOGIX test.

22. LIVER and GALLBLADDER: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

- [ ] Pain under right side of rib cage
- [ ] Frequent skin rashes
- [ ] Bitter metallic taste in the morning
- [ ] Bowel movements painful or difficult
- [ ] Low energy, weakness, exhaustion
- [ ] Upset from greasy/ fatty foods
- [ ] Frequent headaches
- [ ] Pain between shoulder blades
- [ ] General feeling of poor health
- [ ] Aching muscles
- [ ] Feeling of nausea
- [ ] Frequent use of laxatives
- [ ] History of gallbladder issues
- [ ] History of hepatitis
- [ ] History of jaundice
- [ ] Sneezing attacks
- [ ] Itchy skin, worse at night
- [ ] Stools light coloured
- [ ] None of the above

PAUSE & REFLECT: lots of information is being requested

Every question has a purpose, you **do not** need to remember every detail. You may not have all your vaccination details, that is ok. Once we receive the form, we will look through it and we look for patterns. Although this form is divided into sections, holistic wellbeing is not 'sectioned'. We will integrate all the sections following your session to get a more in-depth case history.

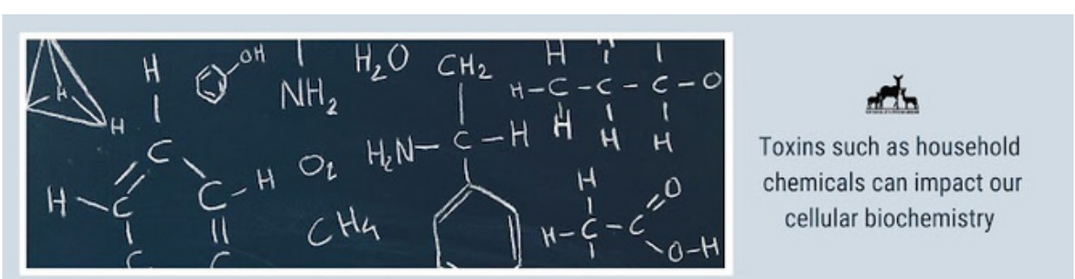
You may also notice some connections as you fill in the form. You may notice your symptoms started, following a medical procedure, or following an emotional event, this event can be a happy or sad event. This form is just as much to allow you to reflect back on your health journey as well as for us to gather information and provide the best support we can. Take a pause if needed and come back to complete the rest.

23. THYROID: Select any of the below that refer to you currently with regular frequency.

Check all that apply.

- [ ] Insomnia
- [ ] Can't gain weight
- [ ] Highly emotional
- [ ] Night sweats/ shakes
- [ ] Inward trembling
- [ ] Increased appetite without weight gain
- [ ] Eyelids and/or face twitch
- [ ] Can't work under pressure Nervousness
- [ ] Intolerance to heat
- [ ] Flush easily
- [ ] Thin, moist skin
- [ ] Heart palpitations
- [ ] Pulse fast at rest
- [ ] Irritable and restless
- [ ] Slow pulse, below 65
- [ ]
- [ ] Night sweats/ shakes
- [ ] Decrease in appetite
- [ ] Ringing in ear
- [ ] Dry or scaly skin
- [ ] Mental sluggishness
- [ ] Headaches upon rising wear off during the day
- [ ] Increased frequency of urination
- [ ] Increase in weight
- [ ] Fatigue easily
- [ ] Sleepy during the day
- [ ] Constipation
- [ ] Hair coarse, falls out
- [ ] Impaired hearing
- [ ] Reduced initiative
- [ ] None of the above

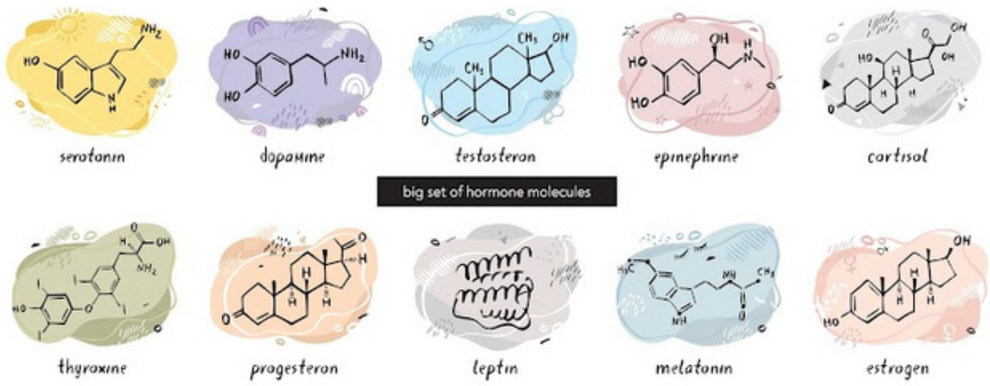
24. ENVIRONMENT: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

- [ ] Exposure to fumes i.e. paint, salon, car
- [ ] Skin disorders e.g. psoriasis, hives
- [ ] Live near power lines/mobile masts
- [ ] Mercury fillings (silver ones)
- [ ] Use of household chemicals
- [ ] Use pesticides
- [ ] Loss of hair
- [ ] PC work
- [ ] None of the above

25. PITUITARY: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

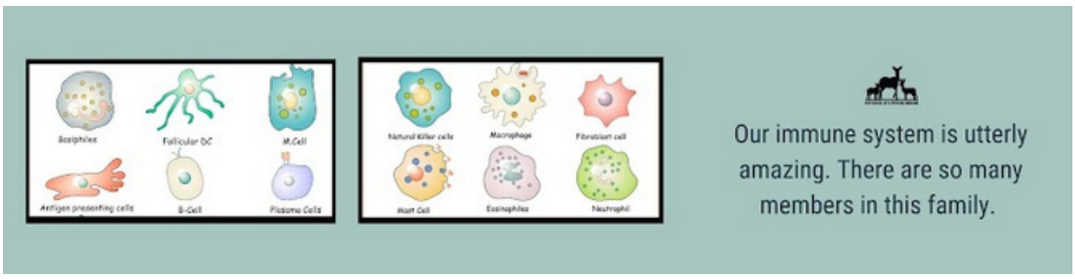
- [ ] Increased/ decreased sugar tolerance
- [ ] Low blood pressure
- [ ] Headaches
- [ ] Failing memory
- [ ] Increased sex drive
- [ ] Bloating of abdomen
- [ ] Weight gain around hips or waist
- [ ] Tendency to ulcers
- [ ] Menstrual disorders
- [ ] Lack of menstruation
- [ ] Reduced sex drive
- [ ] None of the above

26. ADRENALS: Select any of the below that refer to you currently with regular frequency.

Check all that apply.

- [ ] Dizziness
- [ ] Hot flushes
- [ ] Hair growth on face/body (female)
- [ ] Sugar in urine not diabetes
- [ ] Headaches
- [ ] Increased blood pressure
- [ ] Masculine features
- [ ] Asthma
- [ ] Chronic fatigue
- [ ] Respiratory disorders
- [ ] Poor circulation
- [ ] Swollen ankles
- [ ] Bowel disorder
- [ ] Low blood pressure
- [ ] Weakness, dizziness
- [ ] Allergies
- [ ] Brown spots or bronzing skin
- [ ] Crave salt
- [ ] Arthritic tendencies
- [ ] Nails weak, rigid
- [ ] Exhaustion
- [ ] None of the above

27. IMMUNITY: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

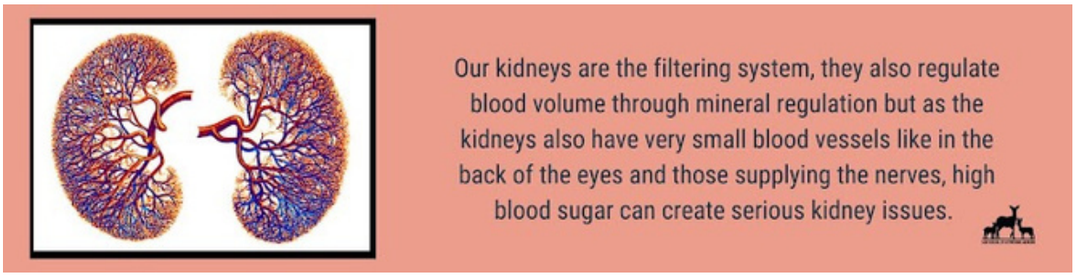
- [ ] Child with chronic immune disturbances
- [ ] Enlarged glands
- [ ] Skin irritation and eczema
- [ ] Chronic/Acute stress overload
- [ ] Lymph nodes swelling
- [ ] Re-current minor infections
- [ ] Throat infections
- [ ] Poor wound healing
- [ ] Slow recovery from illness
- [ ] Boils or styes
- [ ] Swollen lymph glands
- [ ] Cold/ flu frequently
- [ ] Bumpy skin on arms
- [ ] Inflamed or bleeding gums
- [ ] Cough with mucus
- [ ] Swollen tongue
- [ ] Dark areas under eyes
- [ ] Sore throat
- [ ] Postnasal drip
- [ ] Earaches and infections
- [ ] Herpes/cold sores
- [ ] None of the above

28. RESPIRATORY SYSTEM: Select any of the below that refer to you currently with regular frequency.

Check all that apply.

- [ ] Allergies
- [ ] Wheezing
- [ ] Shortness of breath
- [ ] Smoking
- [ ] Grief/sadness/crying
- [ ] Chest pain
- [ ] Asthma
- [ ] Chronic cough
- [ ] Excessive mucous
- [ ] Experiencing loss
- [ ] Cold/flu
- [ ] Skin issues
- [ ] None of the above

29. FILTERING SYSTEM: Select any of the below that refer to you currently with regular frequency.



Check all that apply.

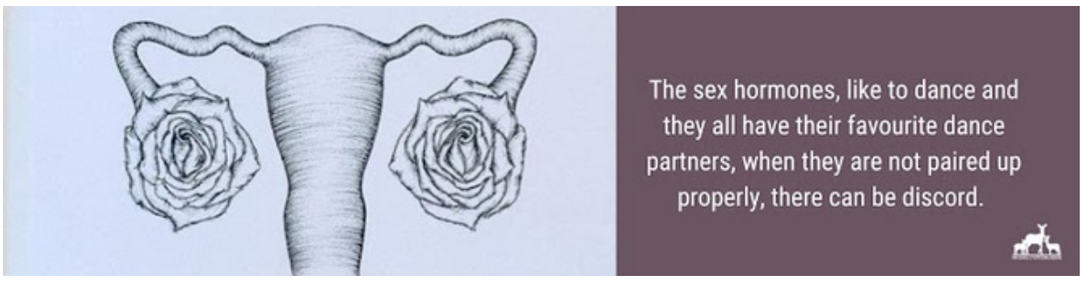
- [ ] Water retention
- [ ] Gout
- [ ] Fatigue
- [ ] High blood pressure
- [ ] Fear
- [ ] Low Blood pressure
- [ ] Frequent urination
- [ ] Weakness of the knee
- [ ] Legs nervous at night (Involuntary movement)
- [ ] Poor memory
- [ ] Lower back pain
- [ ] Difficult urination
- [ ] Dizziness
- [ ] Kidney stone/problems
- [ ] Spinal arthritis
- [ ] Fear/feeling insecure
- [ ] Ringing in ears
- [ ] Low sex drive
- [ ] Blood in urine
- [ ] Incomplete emptying of bladder
- [ ] Frequent kidney/bladder infections
- [ ] Painful urination
- [ ] Difficulty starting the stream
- [ ] Insecurity, fear

30. MALE: Select any of the below that refer to you currently with regular frequency.

Check all that apply.

- [ ] Tire too easily
- [ ] Prostate disorder
- [ ] Urination difficult or dripping
- [ ] Avoid activity
- [ ] Pains on inside of legs or heels
- [ ] Leg nervous at night (involuntary)
- [ ] Overwhelmed
- [ ] Financial stress
- [ ] Unfulfilling occupation
- [ ] Diminished sex drive
- [ ] Lack of energy
- [ ] Migraine headache
- [ ] Incomplete bowel movement
- [ ] Frequent night urination
- [ ] Depression
- [ ] Job stress
- [ ] Feeling inadequate
- [ ] Loss of control

31. FEMALE: Select any of the below that refer to you currently with regular frequency.

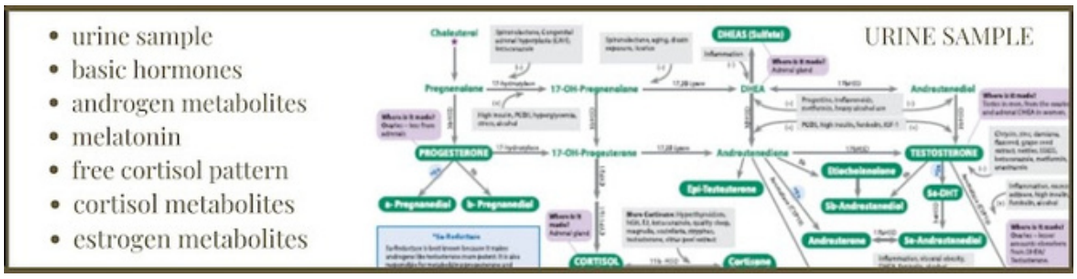


Check all that apply.

- [ ] Long standing depression
- [ ] Low feelings before menstruation
- [ ] Headache before or during menses
- [ ] Menopausal hot flashes
- [ ] Pre-menstrual tension
- [ ] Painful breasts
- [ ] Too frequent menstruation
- [ ] Migraine headache
- [ ] Obsessive dietary habits
- [ ] Vaginal discharge
- [ ] Uterine fibroids, cysts
- [ ] Retaining fluid during/before period
- [ ] Unable to trust anyone
- [ ] Unfulfilling occupation
- [ ] Carrying undesirable responsibilities
- [ ] Overwhelmed
- [ ] Lack of fulfilling relationship
- [ ] Diminished sex drive
- [ ] Lack of femininity
- [ ] Painful menses
- [ ] Very easily fatigued
- [ ] Acne worse at menses
- [ ] Menses scanty or misses
- [ ] Periods excessive/ long
- [ ] Vaginal dryness
- [ ] Hysterectomy
- [ ] Breasts cysts, lumps, mastitis
- [ ] Miscarriage
- [ ] Frequents thrush
- [ ] Feeling inadequate
- [ ] Feeling unloved
- [ ] Difficulty conceiving
- [ ] Stress from abortion(s)
- [ ] Feelings of guilt
- [ ] Feeling rejected
- [ ] Loss of control
- [ ] Lack of romance
- [ ] Feeling put down

Any further information about your hormones, kindly expand below.

32. This section is ONLY if you have submitted a DUTCH test (hormone test).



If female (if male keep reading) Can you tell me a little about your cycles? 1. the duration of your cycles 2. Number of bleeding days 3. ANY symptoms before or during or after the period, such as migraines, low energy, low mood, acne etc 4. If you are peri-menopausal what symptoms are you experiencing and are your periods regular/irregular if so how many days etc? 5. If you are menopausal what are your symptoms such as low moods, anxiety, hot flushes, vaginal dryness, weight gain etc 6. If you are post menopausal when was your last period? If male do you have a family history of prostate cancer? Did you lose hair early in life? Do you have aggression? Do you have the need to urinate often in the night? Do you have a low/high libido?

33. NUTRITIONAL HISTORY: Select any of the below that refer to you.

Check all that apply.

- [ ] Breast fed
- [ ] Vegetarian
- [ ] Vegan
- [ ] Pescatarian
- [ ] Meat and Vegetables
- [ ] Fat restriction
- [ ] Salt restricition
- [ ] Calorie restriction
- [ ] History of yo-yo dieting

34. How many portions of FRUIT do you eat a day? Tick answer

- [ ] 1 -2
- [ ] 3 -5
- [ ] More than 5

35. How many portions of VEGETABLES do you eat a day? Tick answer

- [ ] **1-2**
- [ ] 3 -5
- [ ] More than 5

36. How much water do you drink in a day? Tick answer

- [ ] 500ml
- [ ] 500ml-1L.
- [ ] 1L-2L
- [ ] More than 2L

37. Are you a....

- [ ] Smoker
- [ ] Non-Smoker

38. How many units of alcohol do you drink per week**?** Tick answer

- [ ] 1-2
- [ ] 3-4
- [ ] 5 or more
- [ ] do not drink alcohol

39. How many days per week do you exercise? Tick answer

- [ ] 1-2 days
- [ ] 3-4 days
- [ ] 5-6 days
- [ ] 7 days

40. What type of activities do you do to move your body and elevate your heart rate?

41. FOOD DIARY: Please write down all the foods and drinks you consume over an average TWO DAY day period. * Include everything consumed from the moment you wake to the moment you fall asleep.

42. Are there any foods that you would find difficult to 'cut out' of your lifestyle?

43. Is there any additional information you would like to provide?

44. Do you confirm you have requested Nutritional Medicine and/or coaching support from the NSoNM School Clinic? Tick answer

☐ Yes ☐ No

45. FORM OF CONSENT TO TREATMENT: I confirm that I request Nutritional and/or Coaching advise from the NSoNM School Clinic. I understand that information pertaining to my case will also be used for educational purposes within the NSoNM clinic. SIGN BELOW.

Signature

Today's Date *Date/Month/Year*

Thank you! Kindly email this completed form to your student practitioner at least 72 hours before the first session.You will receive an email with a zoom link . If not check the spam folder. We look forward to supporting you on your health journey.