**DUBAI HOMEOPATHY HEALTH CENTRE**

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**Patient Questionnaire-Adult Male (18 Years+)**

**(Private and Confidential)**

**Full Name:**

|  |  |  |  |
| --- | --- | --- | --- |
| **File:** | **Ethnicity:** | **Weight:** | **Height:** |
| **DOB**:  | **Occupation:** | **Nationality:** | **BP:** |
| **Marital Stat:**  | **ICD Code:** | **Children:** | **RBS:** |

**Important Note: Selection of the correct homeopathic remedy and treatment plan requires an in-depth understanding of the personality type and the body type of an individual. Some of the questions here might seem irrelevant to you but they are not. You can help yourself better by providing answers to all of the following questions accurately and in as much detail as possible. The effectiveness of the treatment entirely depends on this informartion. This information would be kept strictly confidential.**
Describe your chief complaints starting from the newest to oldest health issues:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the symptoms you experience in detail: What exactly do you feel?
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What is the location of the complaint? More on left side or right?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How frequently does it happen?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Since when do you suffer from it?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What makes it better?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What makes it worse?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What other symptoms do you experience alongwith it?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Known diagnosis (please attach copies of all the latest available test reports)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications you are currently on:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Did you develop any of your complaint since:**

A particular major event or a change in life? No clear reason
(example: a shock, an accident, death of a loved one, divorce,
moving countries, moving house, change of job,An illness, accident or an injury,Being in a stressful situation,Use of medication, drugs or substance abuse, Other reason \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What has changed about your personality, behavior, mood or the way you feel since developing your current symptoms?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**List all surgeries you have undergone till date:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
List all major illnesses/disease conditions in the past, before developing your current symptoms:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How often do you get fever?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
What is the highest fever do you remember having last and when?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suffer from any symptoms/complaints on a recurrent basis?

(examples: frequent colds/cough, allergic reactions, sleep disorders,
anxiety, depression, respiratory infections, headaches, digestive upsets, back pain, hayfever in a particular season etc.)

Are you hypersensitive or allergic to anything?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family medical history: (Example: obesity, high blood pressure, heart disease, diabetes, cancer, auto immune disease etc.)
a. Father’s side of the family:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
b. Mother’s side of the family:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
c. Siblings:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
d. Other first relatives:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your mother’s personality? (In 5 words)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
How would you describe your father’s personality? (In 5 words)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal Life History:**

How was your childhood?
Excellent: I had a happy childhood and I do not recall any disturbing event which had a negative effect on my life.
Average: There were some disturbing events but nothing really traumatic.
Poor: There were some disturbing events which have had a negative impact on my life.
Traumatic: I had many disturbing events which have had a profound negative effect on my life.

How was your educational career and student life?

Excellent: I had a smooth and happy educational career.

Average: Nothing remarkably good or bad about my educational career.

I had some difficulties and setbacks which have had some negative impact on my life.

Traumatic: I had many difficulties and setbacks which have had a profound negative effect on me/my life.

If applicable, how has your career path been?

Excellent with verysatisfactory achievements.

Average: there were some setbacks but can be called average/normal.

Poor: I suffered many setbacks in my career which had some negative impact on my life.

Traumatic: I have had major difficulties and setbacks which have had a profound negative impact on my life. .

On a scale of 1 to 10, how happy are you? \_\_\_\_\_

What makes you the most happy?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you the most unhappy?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you had any 3 wishes granted, what would you ask/wish for?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please tick what is relevant and mostly true about you:**I can manage work pressure effectively:

Always Mostly Sometimes Rarely Never

I am able to unwind/relax and recharge myself effectively:

Always Mostly Sometimes Rarely Never

I speak up consistently about what truely matters to me:

Always Mostly Sometimes Rarely Never

I have a healthy work/life balance:

Always Mostly Sometimes Rarely Never

I feel supported by my immediate manager/partner/collegue:

Always Mostly Sometimes Rarely Never

I actively contribute to the happiness and well-being of others:

Always Mostly Sometimes Rarely Never

Overall considering everything, I feel joyful and optimistic:

Always Mostly Sometimes Rarely Never

When I am in a difficult situation, I can find my own way out of it:

Always Mostly Sometimes Rarely Never

I am flourishing at work/business:

Always Mostly Sometimes Rarely Never

I feel inspired to work with my organisation:

Always Mostly Sometimes Rarely Never

Please describe your 3 closest existing personal relationships.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How have your personal relationshipsbeen with:

Mother: Excellent Average Poor Traumatic
Father: Excellent Average Poor Traumatic
Siblings: Excellent Average Poor Traumatic
Wife: Excellent Average Poor Traumatic
Close friends: Excellent Average Poor Traumatic

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Does any past event *still* affect you negatively?Yes No

Please narrate the event and how does it still affect you.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your strengths as a person: (personality traits or habits that help you in day to day life):
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your weaknesses as a person (personality traits or habits that put you at a disadvantage in day to day life or stops you from living a more fulfilling life)
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe yourself as a person?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How expressive are you of your thoughts?

Very expressive. I always speak out my mind.
Moderately. I think and speak out if appropriate.
Rarely. I tend to keep my thoughts to myself

How expressive are you of your feelings and emotions?

Very expressive. I can’t stop myself from expressing my emotions.

Moderately. I am able to express myself emotionally when needed.

Rarely. I tend to bottle up and am unable to express my emotions.

How much do you like company of others?

Love company and being around people.

Don’t mind having company but its not a need.Only prefer company of people who are close to me.

Prefer to be alone.

How much do you feel for other‘s pain or suffering?

Extremely sensitive and get negatively affected by it.

Fairly sensitive and affected by it in some ways.

A bit sensitive but not affected negatively by it.

Not really sensitive. Don‘t think much about it.

How easily do you cry?

Quite easily moved to tears. Anything can make me cry.
Can cry on occasions. But not really very easily.
Am not the crying type. Rarely.
Unable to cry even if I feel sad and would want to cry.

How organized are you?

Extremely organised and must have everything in its proper place.

Fairly organized but not bothered if things are not well organized.
I do not think about being organized.
I tend to be quite disorganized.

How is your sex life?

Highly unsatisfactory Needs improvement Satisfactory

Tick whatever is true regarding to your personality:

I have issues related to anger.

I tend to be anxious easily.

I tend to be impatient.

I tend to feel emotionally insecure.

I tend to feel financially insecure.

I feel homesick.

I feel bored easily.

I usually feel discontented.

I tend to be jealous.

I tend to be suspicious of people.

I tend to lack confidence.

I lack will power.

I do not like responsibility.

I have problems with authority figures.

I tend to feel lonely.

I do not tolerate injustice.

I tend to have strong fears related to:

Death Disease Height Water Dark Ghosts
Looking at blood Being injured Driving Flying Closed spaces/tunnels Poverty Loud noise Thunderstorm
Needles Insects Animals Being alone Strangers
Speaking in public or to a group Examinations Confrontation
Crowded places Being rejected socially Taking responsibility Failure
Opposite sex Horror movies Losing a loved one Accidents
Disasters Making a mistake Danger Being abandoned

How is your memory:

I am extremely forgetful.

I sometimes tend to forget things.

I do not have any problems with my memory.

How is your concentration:

I find it very hard to concentrate on any topic.

I sometimes tend to lose concentration and need to put an effort to focus.
I do not have any problems concentrating.

How is your comprehension:

I always have a lot of difficulty understanding or learning things.
I sometimes find learning or understanding difficult.

I do not have any problems learning new things.

**SLEEP:** Tick all that is mostly true regarding your sleep:

I find it difficult to fall asleep.
I tend to fall asleep too easily.
I have a disturbed or broken sleep.
I am a light sleeper.
I sleep deeply.
My sleep is sound and refreshing.

**Duration:**

I need \_\_\_\_\_\_ hours of sleep per day.
I usually get \_\_\_\_\_\_\_ hours of sleep per day.

**Sleep position:** I usually feel more comfortable sleeping on:

My right side. My left side. My tummy. My back.

Other position.\_\_\_\_\_\_\_\_\_

**Covering during sleep:**

I usually cover myself during sleep.

I usually do not like to cover myself during sleep.

I keep the following parts *uncovered/open*while sleeping:

Head Arms Chest Legs Feet

In my sleep, I usually:

Snore Grind my teeth

Perspire, usually on Head Neck Back All over

Talk Laugh Walk Twitch, jerk or move suddenly.

Toss and turn a lot. Salivate

After sleep, I usually:

Feel tired and unrefreshed.

Wake up with a grumpy mood.
Find it difficult to wake up.

Feel fresh and energetic.

**Dreams:**

I get a lot of dreams. Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dreams disturb my sleep/ wake me up.

I don’t remember my dreams.

**Body Temperature Regulation:** (Please tick all that apply to you):

I often and easily feel warm/hot.
All over Head Feet Back Chest

I often and easily feel cold.
All over Hands Feet Back Chest

I am sensitive to both heat and cold.

I can tolerate both heat and cold comfortably.

I perspire easily.

I mostly perspire a lot from

 Hands Feet Head Underarms Back
Chest Face Whole body

I do not perspire easily.

I do not perspire at all.

My perspiration tends to be smelly.

I am negatively affected by:

Changes of weather Cold weather Hot weather Dry weather
Humid weather

I prefer to shower/bathe with:

Hot water Warm water Room temperature water Cold water

**Digestion:**

Usual frequency of passing stools: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Usual type of stool: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Difficulty in passing if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Usual frequency of passing urine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Difficulty in passing if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I usually suffer from and it is caused by: (Please tick and fill)

Acidity: Usually caused by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Indigestion: Usually caused by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bloating/gas: Usually caused by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Constipation: Usually caused by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Heaviness or pain in stomach: Usually caused by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Abdominal cramps: Usually caused by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Excessive burping: Usually caused by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other digestive problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Food and drinks:
I am a vegetarian I am not a vegetarian but do not eat: \_\_\_\_\_\_\_\_\_\_\_\_

Please describe your typical daily diet:

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In between: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of water per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of other liquids per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Smoking per day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcoholic drinks per week, if any:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick the foods which you *stronglylike* or crave:

water, sweets, bread, rice, chips, chocolates, cold drinks, ice-cream, meat, chicken, fish, spices, milk, cheese, eggs, vegetables, fruits, soft drinks, tea, coffee, salt, lemon, fried food, fast food
spicy food, onions, bitter foods
other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please tick the foods which you *stronglydislike* or hate:

water, sweets, bread, rice, chips, chocolates, cold drinks, ice-cream, meat, chicken, fish, spices, milk, cheese, eggs, vegetables, fruits, soft drinks, tea, coffee, salt, lemon, fried food, fast food
spicy food, onions, bitter foods
other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any foods which do not suit your body? Or you are allergic to?
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Intolerant to? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hair, Nails and Skin:**

Do you have any complaints with your hair, nails or skin?Yes No

**Hair:**

Hair fall Dandruff Premature graying of hair
Other problems with hair

**Nails:**

Brittle or weak nails Discoloration or spots on nails
Ingrowing toenails Slow growth of nails Other problem with nails

**Skin:**Dryness of skin

Too oily skin

Scars or discoloration of skin

Tendency to acne or pimples

Other problems with skin

**Energy levels:**On a scale of 1 to 10, 1 being very low energy and 10 being very high levels of energy, how would you rate your general energy level?\_\_\_\_\_\_

When do you experience high levels of energy:
Morning Forenoon Afternoon Evening Late evening Night

Low energy:
Morning Forenoon Afternoon Evening Late evening Night

How do you like doing physical activities/exercise/sports?
Must do it regularly and enjoy it. (almost daily)

Do it quite often and enjoy it. (a few times a week)

Do it occasionally. (a few times a month)

Do it but have to push myself to do it.

Don’t do any physical exercise.

**Confidentiality declaration and disclaimer:**By signing below, I hereby agree to the following:

I understand that the information provided by me would be kept confidential and my identity would not be revealed without my consent. However, I permit the provided data to be shared with other medical professionals to ascertain the right course of treatment for me and/or for research, statistical and educational purposes.

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:**

**Date:­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**