

Application Form for Consultation

Section 1 of 4 - Personal Details

First name: _____

Last name: _____

Address: _____

Postcode: _____

Telephone: (W) _____

(H) _____

(M) _____

Fax: _____

Email: _____

Gender: Male Female (please circle)

Date of Birth: (year)_____ (month)_____ (day)_____

Body: Height _____ Weight _____ Blood Pressure _____ / _____

A brief description of current and previous occupations:

Current Occupation: _____

Duration (yrs/months): _____

Previous Occupations: _____

Duration (yrs/months): _____

Duration (yrs/months): _____

Type of consultation required (please circle): By Telephone In Person

Give a brief description of the ailment(s) you wish to remedy:

List any alternative therapies used before if any:

Have you consulted with a qualified nutritionist before? (Yes/No) _____

Have you consulted with a GP about any ailments you may wish to remedy through nutritional medicine?

(Yes/No) _____

Section 2 of 4 - Dietary Details

Dietary Record

Please give a full account of the foods/drinks taken yesterday as per the day times given below. Please give as much detail about the makeup, quality and preparation of your meals as you can remember. If nothing is taken please specify. Leave fields empty only if you don't remember:

Time of day	Description of food and/or drink
Waking:	_____

Breakfast:	_____

Mid-morning:	_____

Lunch:	_____

Mid-afternoon:	_____

Evening meal:	_____

Bedtime:	_____

Dietary History

Please give an account of three foods/drinks *typically taken on any given day* in your past as per the day times given below. Please give as much detail about the makeup, quality and preparation of your meals as you can remember. If nothing was taken please specify. Leave fields empty only if you don't remember:

Time of day	Description of food and/or drink
Waking:	_____

Breakfast:	_____

Mid-morning:	_____

Section 2 of 4 - Dietary Details Continued....

Dietary History Continued....

Lunch: _____

Mid-afternoon: _____

Evening meal: _____

Bedtime: _____

List all the drinks you take per day and how much of each:

Water: On average, how many glasses of water a day do you drink? _____

Section 3 of 4 - Symptomatic Indicators

Section 3: 1

Please put **two ticks** against any of the symptoms (below) you are having now or is recurrent and **one tick** against any you may have had in the past.

<input type="checkbox"/> Irritability	<input type="checkbox"/> Uncontrollable Temper	<input type="checkbox"/> Depression
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Foggy Mind	<input type="checkbox"/> Lightheaded
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Phobias	<input type="checkbox"/> Unexplained Anger	<input type="checkbox"/> Catarrh
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Panic attack	<input type="checkbox"/> Tremors
<input type="checkbox"/> Runny nose	<input type="checkbox"/> Repeated colds	<input type="checkbox"/> Hay fever
<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Cravings (sweet/starch)
<input type="checkbox"/> Low energy	<input type="checkbox"/> Tired (waking)	<input type="checkbox"/> Aches and pains (waking)
<input type="checkbox"/> Oedema	<input type="checkbox"/> Bags under eyes	<input type="checkbox"/> Always stressed
<input type="checkbox"/> Constipation		
<input type="checkbox"/> Puffed face (waking)		

Section 3: 2 - 24

Please complete the vitamin and mineral deficiency assessments below. Place **two ticks** on the line if any of the symptoms you have is severe and **one tick** if it is moderate or mild. Many symptoms are repeated in this form, this is due to the way we analyse your results. Please fill in details for every symptom, even if it is a repeat.

Section 3: 2

- | | | |
|--|--|---|
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Mental confusion |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Water retention | |

Section 3: 3

- | | | |
|--|--|--|
| <input type="checkbox"/> Sore knees | <input type="checkbox"/> Muscle twitching | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Poor sense of balance | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Growing pains |

Section 3: 4

- | | | |
|--|--|---|
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Premature ageing | | |

Section 3: 5

- | | | |
|--|---|--|
| <input type="checkbox"/> Muscle tremors or spasms | <input type="checkbox"/> Weakness | <input type="checkbox"/> Leg cramps |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Fits or convulsions | <input type="checkbox"/> Hyperactivity | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Pre-menstrual syndrome | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Loss of appetite | |

Section 3: 6

- | | | |
|--|--|------------------------------------|
| <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Muscle tremors | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tooth decay | <input type="checkbox"/> High blood pressure | |

Section 3: 7

- | | | |
|---|---|---|
| <input type="checkbox"/> Sore tongue | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heavy periods or blood loss |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Nausea | <input type="checkbox"/> Listlessness |

Section 3: 8

- | | |
|--|---|
| <input type="checkbox"/> Craving sweet/ starchy food | <input type="checkbox"/> Addicted to sweet foods |
| <input type="checkbox"/> Irritability when meals missed | <input type="checkbox"/> Frequently hungry |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Need for excessive sleep |
| <input type="checkbox"/> Unexplained drowsiness | <input type="checkbox"/> Cold sweats |
| <input type="checkbox"/> Excessive sweating | |

Section 3: 9

- | | | |
|--|--|---|
| <input type="checkbox"/> White marks on fingernails | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Stretch marks |
| <input type="checkbox"/> Acne, psoriasis or eczema | <input type="checkbox"/> Greasy skin | <input type="checkbox"/> Fertility problems |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Prone to depression | <input type="checkbox"/> Pale skin |

___ Poor wound healing ___ Mouth ulcers ___ Decreased sense of smell
___ Decreased sense of taste ___ Delayed sexual maturity ___ Halitosis

Section 3: 10

___ Lack of energy ___ Diarrhoea ___ Insomnia
___ Headache and migraines ___ Poor memory ___ Anxiety and tension
___ Depression ___ Bleeding or tender gums ___ Acne

Section 3: 11

___ **Burning feet or tender heels** ___ Muscle tremors/cramps ___ Poor concentration
___ Nausea or vomiting ___ Exhaustion after light exercise
___ Teeth grinding ___ Anxiety and/or tension

Section 3: 12

___ **Water retention** ___ **Lack of energy** ___ Tingling of hands
___ Depression or nervousness ___ Irritability
___ Muscle tremors and/or cramps

Section 3: 13

___ **Lack of energy** ___ Poor hair condition ___ Eczema or dermatitis
___ Mouth over-sensitive to hot & cold ___ Irritability
___ Tension and anxiety ___ Constipation ___ Sore and tender muscles

Section 3: 14

___ **Lack of energy** ___ Cracked lips ___ Tension and anxiety
___ Poor memory ___ Poor appetite ___ Stomach pains
___ Depression

Section 3: 15

___ **Mouth ulcers** ___ **Frequent colds or infections**
___ Dry flaky skin ___ Poor night vision ___ Acne
___ Dandruff ___ Thrush and cystitis ___ Diarrhoea

Section 3: 16

___ **Joint pain and stiffness** ___ **Rheumatism or arthritis** ___ Backache
___ Tooth decay ___ Hair loss ___ Excessive sweating
___ Muscle cramps or spasms ___ Lack of energy

Section 3: 17

___ **Exhaustion after exercise** ___ **Easy bruising** ___ **Slow wound healing**
___ Lack of sex drive ___ Varicose veins ___ Loss of muscle tone
___ Infertility

Section 3: 18

___ **Frequent colds** ___ **Frequent infections** ___ Lack of energy
___ Bleeding and tender gums ___ Easy bruising ___ Nose bleeds

___ Slow wound healing

___ Red pimples on skin

Section 3: 19

___ Rapid heart beat

___ Stomach pains

___ Irritability

___ Tingling of hands

___ Prickly legs

___ Eye pains

___ Constipation

___ Poor concentration

___ Tender muscles

Section 3: 20

___ **Dry, rough skin**

___ **Poor appetite or nausea**

___ **Tender or sore muscles**

___ Eczema and dermatitis ___ Premature greying

Section 3: 21

___ **Dry rough skin**

___ **Dry eyes**

___ **Growth retardation**

___ Visual impairment

___ Constipation

___ *Arthritis

___ Poor memory

___ High blood pressure

___ Eczema

___ Slow wound healing

___ **Angina**

___ **Hair loss**

___ **Cracked nails**

___ Dry scalp or dandruff

___ Mal-digestion, flatulence, bloating

___ Miscarriages (females)

___ Excessive thirst

___ Depression

___ Liver problems

___ **Chest pain**

___ **Behavioural disturbances**

___ Learning disability

___ Poor hair condition

___ Frequent colds and sickness

___ Infertility

___ Lack of motivation

___ Excessive thirst

Section 3: 22

___ **Burning gritty eyes**

___ Cataracts

___ Split nails

___ **Sensitivity to bright light**

___ Dull or oily hair

___ Cracked lips

___ Sore tongue

___ Eczema or dermatitis

Section 3: 23

___ **Cardiac symptoms**

___ Growth retardation

___ Fat intolerance

___ Kidney problems

___ Gastric ulcers

Section 3: 24

___ **Hair loss**

___ High cholesterol

___ **Constipation**

___ Eczema

Section 4 of 4 - Confirm Details

I understand that the information supplied will be used by the nutrition consultant to assess my nutritional status. I confirm that the details provided in this application are true and correct to the best of my knowledge.

Name (IN PRINT): _____

Signature: _____

Date: _____

EXETER NUTRITIONAL CLINIC LIMITED

THIS IS A LOCKED DOCUMENT FOR PRINTING ONLY AND IS UNEDITABLE.

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