General Health Questionnaire. *This form is designed to assist your Health Coach to understand your unique concerns. The information is confidential.*  *Please answer as honestly as possible and let us know if there are any questions you are not comfortable answering.*

|  |  |  |
| --- | --- | --- |
| Name: |  | Date of visit: |
| Address: |  |  |
| Birthdate: | Age: | Occupation: |
| Phone number: | Mobile: | Email: |
| Next of kin’s name and number: |  |  |
| Are you currently under the care of another health care provider (GP, specialist, other)? |
| Health provider’s name and contact details: |  |  |
| Current Medications and supplements: |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Primary reason for visit: |  |  |
|  |  |  |
|  |  |  |
| When did you first notice it? |  | Is it getting worse? |
| What stressors were happening then? |  |  |
| What makes it worse? (eg weather, food,)) |  |  |
| Does it interfere with: | Sleep |  | Work |  | Recreation |  | Other |
| What treatment have you had? |  |  |
|  |  |  |

|  |  |  |
| --- | --- | --- |
| Medical History – please list any: |  |  |
| • allergies |  |  |
| • surgery and other procedures (what and when)  |  |  |
| • replacements or implants |  |  |
| • accidents or trauma including falls and injuries to sacrum or tailbone |  |  |
| • fractures and dislocations |  |  |
| • vaccinations |  |  |

Please indicate with a ‘**P**’ (past) ‘**C**’ (current) ‘**F**’ (family) if any of the conditions below apply:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Headaches. Type: |  | Sciatica |  | Depression |  | Contact lenses |
|  | Cold hands or feet |  | Painful/swollen joints |  | Sleep disturbance |  | Artificial/ missing limbs |
|  | Swollen ankles |  | High/low blood pressure |  | Fainting spells |  | Hot feet at night |
|  | Sinus conditions/ frequent colds |  | Dentures/ partials |  | Loss of memory |  |  |
|  | Seizures |  | Pins and Needles: arms, legs, hands or feet? |  | Varicose veins/ haemorrhoidsLocation: |  |  |
|  | Loss of smell or taste |  | Spinal problems |  | Muscular tensionLocation: |  |  |
|  | Skin disorders. Type: |  | Anxiety |  | Herniated/ bulging discs |  |  |
|  |  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Do you use any of the following: |  |  |
| Tobacco? | Quantity per day? | **Alcohol?** | Glasses per day? |
| Marijuana? | Quantity? | Other: |
| Have you been under treatment for substance use? |
|  |

**Where are your scars/troubles – please show above**

|  |  |  |  |
| --- | --- | --- | --- |
| Relative | Medical conditions if still living | Or, cause of death | Age at death |
| Mother |  |  |  |
| Father |  |  |  |
| Siblings |  |  |  |
| Siblings |  |  |  |
| Grandparents on Mother’s side |  |  |  |
| Grandparents on Father’s side |  |  |  |

**Objective Assessment: Areas of Pain, Muscular Tension and Soreness.**

**Female Reproductive Health History**

|  |  |  |
| --- | --- | --- |
| When did you begin your periods? | What was this like for you? |  |
| Do you have regular periods with cycles of consistent length? Yes/ No | Length of cycle: |
| **If you have period pain, how severe is it? Please circle.** |
| **I don’t get period pain** | **Mild cramping** | Painful cramping | Very painful cramping | Extreme pain |
| **How many days do you bleed for, and how heavy is the flow?** |
| **Circle the contraceptive methods you’ve used and indicate length of time:** |
| Pill | Patch | IUD | Diaphragm | Condom | Fertility aware | Injection | Other: |
|  |  |  |  |  |  |  |  |
| Have you used the contraceptive pill, for how long, and were there any side effects? |
| Do you have any pelvic pain? Yes/ No | During which part of your cycle? |
| Have you had any periods of amenorrhoea? |
|  |

**Please tick as appropriate:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | Painful periods |  | Irregular cycles (early or late) |
|  | Dark, thick blood at beginning of cycle |  | Dark, thick blood at end of cycle |
|  | Headache or migraine with period |  | Dizziness with period |
|  | Bloating/ water retention with period |  | Heaviness in pelvis with period |
|  | PMS/ Depression with or before period |  | Excessive bleeding (>one pad per hour) |
|  | Failure to ovulate |  | Painful ovulation |
|  | Varicose veins |  | Tired weak legs |
|  | Numb legs and feet when standing |  | Sore heels when walking |
|  | Low back ache |  | Painful intercourse |
|  | Constipation |  | Endometriosis |
|  | Cysts, especially breast / ovarian |  | Uterine polyps |
|  | Fibroids |  | Vaginal discharge/ vaginitis |
|  | Bladder infections/ incontinence |  | Chronic miscarriage |
|  | Weak newborn infants |  | Premature deliveries |
|  | Incompetent cervix |  | Spotting with pregnancy |
|  | Pelvic inflammation |  | Sexually transmitted disease |
|  | Dry vagina |  | Difficult menopause |
|  | Cancer, especially in reproductive area |  | Other? |

**Pregnancies**

|  |  |
| --- | --- |
| Are you trying to conceive? Yes/ No | How long have you been trying? |
| Are you or your partner having any treatment for infertility (IVF etc)? |  |
| How many pregnancies have you had? |  |
| Terminations: | Dates: |
| Miscarriages: | Dates: |
| Live births: | Dates: |
| Still births: | Dates: |
| Complications? |  |
| What was your experience of: |  |
| Pregnancy: |  |
| Labour: |  |
| Birthing: |  |
| Post partum: |  |
| Your own birth |  |
| Did your mother take any medications during pregnancy? Which ones: |  |
| Any known birth trauma: |  |

**Menopause**

|  |  |
| --- | --- |
| Have your periods worsened or improved with age? Please describe. |  |
| If you get hot flushes, how often and severe are these? |  |
| How has your weight changed since beginning menopause? |  |
| To what extent have your energy levels changed? |  |
| To what extent have your moods changed? |  |
| To what extent have your digestion and elimination habits changed? |  |
| Have menopausal symptoms worsened with age? |  |
|  |  |
|  |  |

**Eating habits**

|  |  |
| --- | --- |
| What do you choose to eat (give details of your current diet) |  |
|  |  |
| Why? (allergic etc) |  |
| Foods you avoid: |  |
|  |  |
| Why? |  |

**Which substances and stimulants do you use:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Coffee** |  | **Caffeinated tea (black or green)** |  | **Alcohol** |
|  | **Cigarettes** |  | **Other recreational drugs:** |
|  |  |  |  |

**Which types of sugar do you consume:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Fruit** |  | **Unrefined sugar treats** |  | **Cakes, biscuits, sweets** |
|  | **Honey, maple syrup, dates** |  | **Other:** |
|  |  |  |  |

**Salt and Fat**

|  |
| --- |
| **Do you add salt to your food? Yes/ No What kind of salt?** |
| **Have you been restricting or avoiding salt? Yes/ No For how long?** |
| **What fats do you consume?** |
| **What would you change about your eating if you could?** |
|  |

**Prescription Medication:**

|  |
| --- |
| **Are you taking any? Please list.** |
|  |
| **What for?** |
| **How long have you taken it?** |
|  |
|  |

**Hydration**

|  |
| --- |
| **How much water do you drink per day?** |
| **Where does it come from?**  |
| **When do you drink water?** |
| **What temperature is it? (eg chilled, room temp, hot)** |

**Toilet info: Bladder habits**

|  |  |
| --- | --- |
| **How often do you pee?** | **Does it flow easily? Yes No** |
| **Does your bladder feel empty afterwards?** |  | **Yes** |  | **No** | **Does it hurt or burn when you pee?**  |  |  |  |  |
| **Do you experience any other issues with urination?** |
|  |

**Bowel habits**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **How often do you go?** | **Is it easy to stay regular?**  |  | **Yes** |  | **No** |
| **Which part of the day is usual for you?** |
| **When you go, does it feel like it’s complete (bowel has emptied?)**  |  | **Yes** |  | **No** |
| **What is the consistency of your stools? Please choose below** |
|  | **Hard pellets** |  | **Bulky log, difficult to pass** |  | **Long and floating** |
|  | **Long, curved ‘S’ shape** |  | **Runny porridge consistency** |  | **Very runny, no shape** |
|  | **Thin stools, but elimination completes** |  | **Thin stools, incomplete elimination** |
| **When you go, does it feel like it is complete (bowel has emptied)?**  |  | **Yes** |  | **No** |
| **Do you experience pain before, during or after defecation?** |
| **Do you get haemorrhoids?** |  | **Yes** |  | **No** |
| **Is there undigested food, blood or mucus in your stool?** |  | **Yes** |  | **No** |
| **If so, how often does this happen?** |
| **Do you get black, tarry stools?** |  | **Yes** |  | **No** |
|  |  |  |  |  |
| **Do you have a ‘no fuss gut’ (cast-iron stomach)?** |  | **Yes** |  | **No** |
|  |  |  |  |  |
| **Do you hear gut noises often?** |  | **Yes** |  | **No** |
|  |  |  |  |  |
|  |  |  |  |  |
| **Do you get sharp/stabbing pain?** |  | **Yes** |  | **No** |
|  |  |  |  |  |
|  |  |  |  |  |
| **Do you have vague aching?** |  | **Yes** |  | **No** |
| Where is the pain? |
| How often and when does it happen? |
| Do you experience any other digestive issues? |
| **Sleeping** |
| Can you easily fall asleep? Yes No Can you sleep well anywhere? Yes No |
| Do you dream? Yes No Sometimes Can you remember your dreams? Yes No Sometimes |
| Do you get nightmares? Yes No Sometimes Night terrors? Yes No Sometimes |
| How do you feel when you wake up in the morning? |
| How long does it take for you to truly feel awake in the morning? |
| Do you consider yourself to be a morning person Yes No Do you grind your teeth in your sleep? Yes NoDetails: |
| Extra info |