The Health Works Clinic - Patient Questionnaire

Please complete and bring to your appointment. If you need more space, continue on a blank page.
Your answers are confidential. The more open and helpful you are, the better we can help your health.

Date …… **Name** …… **Birth Date**……

Address: **Street**…… **Town**……

County…… **Postcode**…… **Country**……

Telephone: (1)……☐Home ☐Work **(2)** ……☐Home ☐Work

Email address…… **Occupation** ……

In case of emergency notify: (relationship) …… Phone #: ……

CHIEF COMPLAINT: Referred by:

DENTAL HISTORY: Current no. of dental amalgam fillings (these are silver- or black-coloured): _____

How long since the first one was placed? _____ Total number that have been removed: _____

When removed? _____ Removed by (circle which): (a) a regular dentist or (b) a holistic mercury-free dentist?

Did your mother have amalgam fillings before your birth (circle which)? YES / NO / PROBABLY / NO IDEA

And did your father and/or grandparents (circle which)? YES / NO / PROBABLY / NO IDEA

No. of gold caps, root canals or other dental restorations (indicate which):

EMFs: Your home is a (circle which): House / Apartment? / Which apartment floor? ___ / How many storeys? ___

How far is the nearest: Mobile phone mast _____ / Electricity pylon_____ / High power generator _____ ?

Describe the view from your bedroom window: _____

Do you use (circle which): Cordless phone / Wi-Fi / Electric blanket / Electric shaver / Electric toothbrush / Magnets?

Are there fluorescent lights / striplights / long-life (mercury) lightbulbs in your (circle which): Home / Office ?

Do any direct neighbours have a cordless phone? YES / NO / DON'T KNOW

How many of these do you and residents have? TVs ___ Computers/laptops ___

Do you use a laptop without an external keyboard and mouse? YES / NO

Do you use any phones (circle which): Held to ear / On speakerphone function?

Devices in your bedroom (circle which): TV / Computer / Clock radio / Lamp /

Mobile phone / Other appliances:

	Average Hours of Use Per **Day**:
TV	
Computer or tablet	
Mobile phone	
Landline phone	
In a motor vehicle	

LIST SYMPTOMS IN ORDER OF PRIORITY (worst first): **Rate 1→10: 1=hardly there / 10=extremely bad**

Current Symptom & Description (include any diagnosis as well)	Known triggers / Worse (<) or better (>) for…	When started:	Rating:

Previous major symptoms which you have had but which are now resolved	Known triggers / Worse (<) or better (>) for…	When started:	When ended:

Current Symptom Picture – Generals Circle or tick those that apply:

Energy: Very low / low / medium / high / excessive / erratic Appetite: Very low / low / medium / high / excessive / erratic

Thirst: Very low / low / medium / high / excessive / erratic Exercise: Very low / low / medium / high / excessive / erratic

Circulation/warmth/heat: Very low / low / medium / high / excessive / erratic

Exercise Routine _____ Average sleep in hours _____ Quality: poor / good

Energy is best: ☐ a.m. ☐ p.m. ☐ Night ☐ Between meals ☐ Just after meals ☐ When moving ☐ Or still

Energy is worst: ☐ a.m. ☐ p.m. ☐ Night ☐ Before meals ☐ Just after meals ☐ When moving ☐ Or still

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Mind / Emotions: Tick if apply: ☐Mood swings ☐Anger/frustration ☐Grief/sadness ☐Racing mind ☐Lack motivation ☐ Depressed or Low ☐ Fear/Anxiety/Worry ☐ Brain fog ☐ Poor memory/concentration ☐ Difficulty communicating

Stress: Typical stress level between 1 and 10 (*1 = very relaxed, 10 = very stressed*): ……..

Factors most contributing to your stress: ☐ Health ☐ Work ☐ Money ☐ Family ☐ Other_____

What best helps you deal with your stress?

Male / Female *Note: If you feel ready to be open in this area, the purpose of the following is to enable us to better assist your health.*

Men & women (circle): impotence / lack of interest / discharge / swelling / testicular pain / ED / other:_____

Women only: No. of children: ….. No. of miscarriages: ….. No. of abortions: ….. how long on the Pill: …….

Menses (circle): *late* / *early* / *regular* / *irregular* / *absent*. Period lasts __days Time to next period ___days

Flow: *heavy* / *light* / *regular*. ☐ I suffer from PMS/PMT

List symptoms (circle which): breast swelling/tenderness / cramping / irritability / pain / other _____

☐ Infertility ☐ Pregnant now ☐ Planning pregnancy ☐ Difficult birth(s) → Details: _____

How did you feel while pregnant: Worse / No change / Better If better or worse how?_____

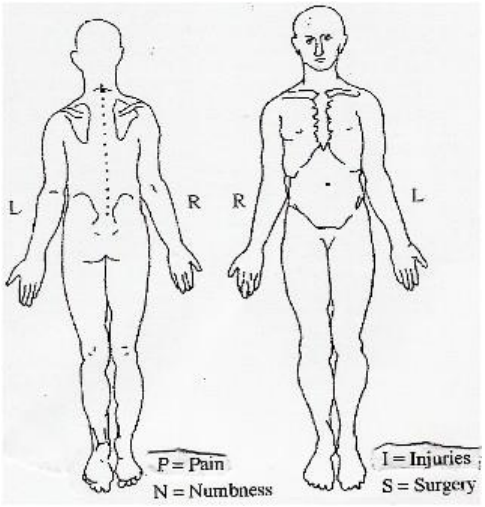
Any complications? → Details: _____

Symptoms Picture – Top-Down Circle any **current** problems & **mark** pain/numbness/surgery/injuries on the picture:

Sleep – Probs. getting to sleep / Freq. waking / Early waking / Wake unrefreshed / Sleepiness / Night sweats

Infections – Recurring / Frequent / Colds / 'Flu / Sinusitis / Chest / Ear / Urethritis / Cystitis / Kidney / Stomach / Food poisoning / Poor immunity / General 'run down' feeling / Sinus congestion / Drip / Phlegm

Head – Headaches / Migraines / Seizures / Panic attacks / Poor hearing / Tinnitis or Ringing / Blurred vision – distance / near / Visual Spots



General – Nausea / Swelling/oedema / Chronic Fatigue / Easily Tired

Extremities (Hands or feet) – Cold / Numbness / Tingling

Lower back/kidney area – Pain/soreness

Chest – Difficulty Breathing / Palpitations / Burning / Pain / Angina /

Urination – Difficulty / Incontinence / Pain / Frequent night visits to toilet

Bowels – Indigestion / Heartburn / Abdominal pain / Bloating / Gas / Rectal itching / *How often do you pass stools?* ……..……..…..

Stools tend to be: Okay / Loose (L) / Constipated (C) / Alternating (L & C)

Nerves, Muscles & Joints – Burning / Numbness / Tingling / Sensitivity / Poor Mobility / Poor Co-ordination / Muscle Weakness / Recurring Pain in: Back / Neck / Shoulder / _____

Skin & Hair – Eczema / Psoriasis / Rash / Itchiness / Dryness / Spots / Athlete's foot / Jock itch / Hair loss

Timeline of medical inteventions - Development of Symptoms - Please list here any events and their corresponding approximate dates which you suspect may have affected your health. Please describe them briefly below in the appropriate boxes. **Please also include reference to antibiotics or vaccines or dental work.**

Life Event and approx. date	Changes in health? If so describe briefly
0 to 10 years	
10 to 20 years	
20 to 30 years	
30 to 40 years	
40 to 50 years	
50 to 60 years	
60 years and thereafter	

OTHER FACTORS OR EVENTS THAT MAY HAVE AN INFLUENCE ON YOUR CURRENT CONDITION

Antibiotics – Approx. total number of courses of **Antibiotics** received in your life: ☐ none ☐ 1-10 ☐ 11-20 ☐ 21+

Antibiotics received as a child – please describe briefly what the treatments were for and at what approximate age:

_____

_____

Antibiotics received as an adult – please describe briefly what the treatments were for and at what approximate age:

_____

_____

When was last one received and for what? _____

Exposure to diagnostic X-rays or x-ray medical treatment:

Approx. total no. of **X-rays** received in your life: ☐ 0-10 ☐ 11-20 ☐ 21+ When was last one received? _____

For what? (mammogramms, injuries, dental, chest, etc…)_____

_____

Vaccination History Approx. total no. of **Vaccinations** received in your life: ☐ 0-10 ☐ 11-20 ☐ 21+

Childhood Vaccines (up to 18 years)

Were you vaccinated as a baby and as a child? YES/NO If so please confirm the country & whether you received the full program or not: _____

_____

Can you remember any reactions to these? _____

Adult Vaccines Have you been vaccinated as an adult? YES/NO If so please confirm what vaccines, the approximate dates and the reasons for receiving those vaccines_____

_____

When was last one received and for what? _____

TRAVEL: Do you travel by aeroplane frequently? YES / NO Average number of plane journeys per month _____

Have you travelled to remotely (eg: Asia/Africa/South America…) YES / NO

Date	Destination(s)	Health Incidents There or After?	Date	Destination(s)	Health Incidents There or After?

YOUR / YOUR FAMILY SYMPTOM & MEDICAL HISTORY: Circle the specific symptoms or condition & tick those that apply to you or your family in the appropriate boxes to the right

	You	Mom	Dad	Grand parents	Siblings	Gene codes indicated
ACHING JOINTS OR MUSCLES						1,3,7
ALLERGIES / ASTHMA / CHEMICAL SENSITIVITIES:						3
ALLERGIC REACTIONS TO FOOD OR AIRBORN ALLERGENS (IgE)						3,4S
ASTHMA						1,3,6
CHEMICAL SENSITIVITIES / MCS (including also perfumes)						1,3,5
HAY FEVER						3
SKIN REACTIONS						3
ANEMIA / FAILURE TO THRIVE / SLOW TO HEAL:						
ANAEMIA						
EXCESS WEIGHT LOSS / VERY THIN						
MALABSORPTION / POOR DEVELOPMENT						
SLOW TO HEAL AFTER INJURY						6
ARTHRITIS / GOUT:						3
OSTEOARTHITIS						
RHUEUMATOID ARTHRITIS						
AUTO-IMMUNE DISEASE OF ANY KIND (SEE LIST*)						1,5
BRAIN - MENTAL/EMOTIONAL PROBLEMS & PSYCHIATRIC DISORDERS						5
ADDICTION PROBLEMS: GAMBLING / SOCIAL MEDIA / RECREATIONAL DRUGS / SUBSTANCE ABUSE / SHOPPING / SOCIAL MEDIA / SUGAR						2F,4F
ANXIETY / PANIC ATTACKS / PANIC DISORDER						1,2S,4S,5
AGGRESSION / ANGER / EDGINESS / IRRITABILITY /ANTI-SOCIAL BEHAVIOUR						3,4F
BIPOLAR / SCHIZOPHRENIA						1,2S,4S,5,6
BRAIN FOG						1
DEPRESSION (all kinds including but not limited to postapartum & S.A.D.)						1,2F,4F,5,6,7
EATING DISORDERS						
LACK OF MOTIVATION / CONFIDENCE						
MEMORY LOSS OR DETERORIATION						
MOOD SWINGS						
OBSESSIVENESS / OCD						4S,5
OVER-REACTIVE / STARTLE EASILY						
WORKAHOLIC						2S
BRAIN - NEUROLOGICAL/NEURO-DEGENERATIVE/DEVELOPMENTAL						1,6
ADD / ADHD / LEARNING DISABILITY / LOW ATTENTION SPAN OR FOCUS						2S,2F,4S,4F
ALZHEIMERS / DEMENTIA						1,4S,4F,5,6
AUTISM / ASD / ASPERGERS / PANDA						1,4S,5
DIZZYNESS / FAINTING / VERTIGO						3
EPILEPSY / SEIZURES						1,5
HEADACHES / MIGRAINES						1,3,4S,5
MILD COGNITIVE IMPAIRMENT						1,4S,4F,5,6
MOTOR NEURON DISEASE						4S,5,6
MULTIPLE SCLEROSIS						1
OTHER NEURO PROBLEMS - TICS/TREMORS/GAIT/FALLING/of unknown origin						1
PARKINSONS						1,3,4S,4F,5,6
CANCER (SEE LIST) nb: for 2S its primarily estrogen related cancers**						1,2S,5,6,7
CARDIO-VASCULAR / HEART DISEASE:						5,6

ANGINA / ACUTE CORONARY SYNDROME						2S,5,6
ARRYTHMIA / TACHYCARDIA (RACING HEART)						3,5,6
ATHERSCLEROSIS, PREIPHERAL ARTERIAL DISEASE						5,6
BLOOD CLOTTING DISORDERS (THROMBSOSIS / EMBOLISMS)						1,5,6
BLOOD PRESSURE, HIGH (HYPERTENSION)						2S,5,6
BLOOD PRESSURE, LOW (HYPO)						3
HEART ATTACK (MYOCARDIAL INFARCTION)						1,2S,5,6
HEART FAILURE / HEART MURMURS / HYPERTROPHY (LV)						1,5,6
STROKE						1,5,6
CHRONIC/FREQUENT INFECTIOUS DS. (suspected or diagnosed)						1,5
CANDIDA / MOLD						5
HERPES: CMV / EBV / HSV / HERPES ZOSTER / HERPES OTH.						5
OTHER VIRUS: HEP A/B/C etc / HPV / INFLUENZA (includes rheumatic fever)						5
LYME: BABESIA / BARTONELLA / BORRELIA / EHRLICHIA						5
OTHER BACTERIA: MYCOPLASMA / STAPH / STREP / TB						5
CHRONIC FATIGUE / CFS / TIRE EASILY / LOW STAMINA						1,5,7
CHRONIC INFLAMMATORY DISORDERS OF ANY KIND						1,5,6
CONGENITAL OR BIRTH DEFECTS OF ANY KIND (SEE LIST*)**						1,6,7
DIABETES & RELATED PROBLEMS:						
BLOOD SUGAR LOWS & HIGHS / SUGAR / CARBOHYDRATE CARVINGS						
DIABETES TYPE 1						5,6
DIABETES TYPE 2 / METABOLIC SYNDROME						5,6
DIABETIC NEUROPATHY/NEPHROPATHY/RETINOPATHY						6
PRE-DIABETES / INSULIN RESISTANCE						
DIGESTIVE PROBLEMS*:						
BLOATING / GAS / INDIGESTION						3,7
CONSTIPATION						7
DIAHRREA						3
FLATULENCE / GAS						
FOOD REACTIONS OR INTOLERANCES (STATE WHICH)						3,4S
GERD / HEARTBURN / ACID REFLUX						3
HEMORROIDS						
IBS / INDIGESTION / ALT DIAHRREA & CONSTIPATION						1,3,4F
IBD (CELIAC DISEASE / ULCERATIVE COLITIS / CROHNS DISEASE)						3,5
LEAKY GUT						3
NAUSEA / VOMITING						3
PEPTIC OR DUODENAL ULCER						3,7
SMALL INTESTINE BOWEL OVERGROWTH (SIBO)						
EAR & HEARING PROBLEMS						
LOSS OF HEARING / DEAFNESS						5
TINNITIS						3
EYE PROBLEMS:						5
ADVANCED MACULAR DEGENERATION						5
CONJUNCTIVITIS / KERATO-CONJUNCTIVITIS						3
GLAUCOMA						1
FERTILITY / PREGNANCY / GYNECOLOGICAL PROBLEMS						1,3,5
ENDOMETRIOSIS						
ERECTYLE DYSFUNCTION						6
GESTATIONAL DIABETES						3,5

INFERTILITY (FEMALE)						5
INFERTILITY (MALE)						1,5
MISCARRIAGE						1,3,5,6
PCOS / CYSTIC OVARIES						
PRE-ECLAMPSIA						2S,3,5,6
UTERINE FIBROIDS						2S
GALL STONES / GALL BLADDER REMOVED						7
GENITAL / URINARY – FREQ. URINATION / PAINFUL URINATION / PCOS / STD / UTI						
HAIR PROBLEMS						
HAIR LOSS / BALDING						
HIRSUTISM						
PREMATURE GREYING / GOING WHITE						4S
KIDNEY FAILURE (CHRONIC)						6
KIDNEY STONES						
LIVER DIS. / FATTY/QUEASY LIVER / SLUGGISH DIGESTION (ESP FATS)						7
MESTRUAL / PMS / PERIOD PROBLEMS:						1,2S
CLOTTING / CRAMPING / BREAST SWELLING OR TENDERNESS						
IRRITABILITY / MOOD SWINGS						
OTHER MENSTRUAL SYMPTOMS_____						
PERIODS - MISSING / HEAVY / LIGHT / PAINFUL						
MENOPAUSE / PRE-MENMOPAUSE (NIGHT SWEATS, HOT FLASHES ETC..)						
NOSE / SINUS PROBLEMS						
CONGESTION / RUNNY NOSE						6
NOSEBLEEDS						3
OSTEOPOROSIS / OSTEOPOROSIS						2F
PAIN - FIBROMYALGIA / CHRONIC GENERALISED PAIN						2S,4S,5
PAIN - INCREASED SENSITIVTY TO PAIN						1,2S,3,7
PERIPHERAL NERVE PAIN OF ANY SORT (WHERE _____)						
PERIPHERAL NUMBNESS / PAIN IN EXTREMITIES (HANDS/FEET/LIMBS)						
RESPIRATORY / BREATHING PROBLEMS (asthma in allergies)						
BRONCHITIS / CHRONIC OBSTRUCTIVE PULMONERY DISEASE (COPD)						
SLEEP APNEA / SNORING						6
SKIN PROBLEMS:						
ACNE						
ECZEMA						3,5
FLUSHING / HIVES / RASHES						3
ITCHING						3,7
PSORIASIS						3,5
ROSACEA						
SWEATING (EASY/EXCESSIVE)						1
SLEEP PROBLEMS (for sleep apnea see respiratory):						
INSOMNIA - TROUBLE GETTING TO SLEEP						2S,3
INSOMNIA - TROUBLE BECAUSE OF WAKING UP						3,4S
NIGHT SWEATS						
NIGHTMARES						
WAKING UP UNREFRESHED						
THYROID DISEASE: HYPOTHYROID / HYPERTHYROID						1,5
WEIGHT PROBLEMS / OBESE / OVERWEIGHT						4F,5,6

FOOD & DIET : Do you follow or try to follow any specific diet? YES /NO If yes, which_____

Please describe typical types of food consumed on any given day (only fill in if regular meal applies – eg: snacks)

Breakfast:_____ typical time ____

Snack:_____ typical time ____

Lunch:_____ typical time ____

Snack:_____ typical time ____

Dinner:_____ typical time ___

Snack:_____ typical time ____

DIET MAKE UP IN GENERAL:

How much do you eat/drink of the following:	None	Very Little	Moderate	Very Much
Vegetables	____	____	____	____
Beans/legumes, nuts, seeds	____	____	____	____
Meat, fish (Which?.....)	____	____	____	____
Chicken, turkey or eggs (not organic, even if free range)	____	____	____	____
Chicken, turkey or eggs (organic)	____	____	____	____
Dairy Foods (milk, cheese, yogurt, etc.)	____	____	____	____
White flour/starches: bread, pasta, potatoes, rice	____	____	____	____
Whole grains: wholewheat, oats, spelt, barley, rye	____	____	____	____
Sweets (cakes, biscuits, puddings, chocolate, soft drinks…)	____	____	____	____
Fruit and/or fruit juice	____	____	____	____

Estimated % of diet which is organic _____% Estimated % of diet from wholefoods _____%

Estimated % of diet made up of green leafy and other bright coloured vegetables _____%

Do you feel worse after eating? Yes / No irritability / sweating / nosebleeds / runny nose / headache /

Other _____ Symptoms begin? ☐ Within 20 min. ☐ After an hour How long last ____ hours

Are you aware of having any food sensitivities / intolerances? Yes / No If yes, foods: _____

Average alcohol weekly: _____ ☐ History of alcohol addiction? You / Family ☐ Sensitive to alcohol/wine

Average water daily: _____ Tap ____ Filter at tap ____ RO / Distilled ____ Bottled _____ Other _____

SMOKING Do you smoke? YES / NO Have you ever smoked (actively or passively)? YES / NO

Packs daily _____ How long _____ When stopped _____

TOXICITY Have you used recreational drugs? YES / NO Which _____ How long _____ When stopped _____

Have you ever been exposed to industrial/chemical toxins at work or home? (e.g. factory/farming…) YES / NO

What chemicals/what industry/how long?_____ When stopped _____

Describe the type and location of your home APPARTMENT / HOUSE COUNTRYSIDE / SUBURBAN / CITY

_____

Have you ever used weed killer or other agricultural chemicals? YES / NO Do your neighbours? YES / NO

Do you use a coal stove/fire (either regular or 'smokeless' coal)? YES / NO Do your neighbours? YES / NO

Do you live near any of the following (i.e. within about 1-2 miles, OR further if downwind) (circle which):

a nuclear plant / crematorium / industrial zone / polluting factory / golf course / agricultural area?

Have you ever been exposed to any other known major environmental toxins? YES / NO If yes, explain:

Briefly list your previous treatment / detoxification history (including conventional or alternative medicine):

WHEN BEGUN	WHEN ENDED	TREATMENT	WHEN BEGUN	WHEN ENDED	TREATMENT

HOSPITALIZATIONS / SURGERIES:

INCIDENT	DATE	INCIDENT	DATE

ACCIDENTS: Ever knocked unconscious? Any blows to the head / spine / other injuries? Details:

CURRENT TREATMENTS:

List medications you currently use (prescribed or over-the-counter): [*BRING A **SAMPLE** OF EACH TO YOUR APPT*]

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

□ Long-term medication(s) *past* / *present* (circle which). Details:

List all the supplements / homeopathics / herbs you are currently taking: [*BRING **SAMPLES** OF THESE TOO*]

NAME	FREQUENCY	DOSAGE	SINCE WHEN	NAME	FREQUENCY	DOSAGE	SINCE WHEN

Is any other practitioner providing treatments/therapies for you at the present time? YES / NO Details:

Questionnaire - Genetic/Epigenetic Profile - tick those that apply

MTHFR (1) ----------

□ I sweat easily when exercising □ I eat supplements with or cereals or other foods fortified with Folic acid
□ I rarely eat leafy green vegetables □ I have a genetic polymorphism in my MTHFR C677 gene □ I get PMS/PMT
□ I suffer from frequent infections □ I get brain fog or anxiety □ I have trouble getting motivated or getting going, mornings
□ I'm very sensitive to pain □ I have had fertility problems □ I'm hypothyroid □ I suffer from chronic fatigue

COMT SLOW (2S) ----------

□ I find falling asleep a challenge □ I easily become anxious or irritable □ I'm sensitive to pain
□ I can study or focus for long periods □ After long periods of hard work, I crash & it takes a long time to recover
□ I'm a bit of a workaholic □ Caffeine makes me stressed or wired □ I have strong bones or skin that glows
□ I had early menarche or I get PMS/PMT or get heavy periods □ I have or had uterine fibroids
□ If I eat a high protein diet (GAPS/Paleo) I get more irritable □ If I get stressed it takes a while to calm down

COMT FAST (2F)----------

□ I crave for carby foods which help my mood for a while then I feel low/depressed □ I tend to be a bit addictive
□ I have problems to focus for long periods □ I have or had ADHD □ I usually don't get stressed about things
□ Or if I ever get stressed, I recover quickly □ I'm quite a calm person / I go with the flow □ I tend to fall asleep quickly
□ I need my coffee/tea in the morinings! □ I do better with high protein meals or diets (GAPs/Paleo)
□ I tend to be more low or lacking motivation than enthusiastic □ I had late menarche / don't get PMS/PMT
□ My periods tend to be light □ I tend to have weaker bones □ I can stand pain well compared to others

DAO (3)----------

□ I'm sensitive any one or more of the following: wine / alcohol / citrus fruit / fish / cheese / shellfish / chocolate
□ I can't tolerate fermented foods (kefir, sauerkraut, etc) □ I often get itchy or my eyes itch □ I get headaches or migraines
□ I felt better during pregnancy / could eat a more varied diet □ I get sweaty feet □ I get nosebeeds
□ I get reactions after eating (irritable / hot / itchy / other) □ I struggle with asthma or difficult breathing
□ I get car sick or seasick or can feel dizzy □ I have skin issues suach as eczema or hives
□ I suffer with heartburn or use antacids □ I seem to react to many foods or have been told I have leaky gut
□ I have ringing in my ears / tinnitis □ I'm prone to loose bowels or diarrhea □ I get arrythmia sometimes
□ I have trouble staying or falling asleep □ I strggle with ulcerative colitis or crohns disease □ I get joint pain
□ I have or can get episodes of low blood pressure (ie: less than 100/60) □ I get asthma / exercised induced asthma / wheezing

MAOA SLOW (4S) ----------

□ I stress or panic or feel anxious easily □ I find it hard to clam down after any upset □ I can get more irritable than I'd like
□ I find it hard to fall asleep but when I do I usually stay asleep □ I tend to breathe faster if stressed □ I can focus for a longtime
□ I enjoy eating cheese, wine or chocolate but tend to feel irritable or "off" after eating them □ I get migraines or headaches
□ It takes me a while to wind down in the evening □ I have a tendency to get a bit obsessive or obsessive/compulsive

MAOA FAST (4F) ----------

□ I fall asleep OK but then wake up earlier than I want □ I'm prone to depression or lack of desire or seasonal affective disorder
□ I tend toward smoking or alcohol addiction (or excessive use) □ I have been diagnosed with ADHD □ I love chocolate
□ I feel better after eating carbs but then I'm less attentive or lose focus easily □ Depression or addiction runs in my family
□ I carve carbs □ I do better if I eat more protein

GST/GPX (5) ----------

□ I'm sensitive to chemicals or smells □Grey hair came early □ I have a chronic condition (asthma, auto-immunity, IBD, skin)
□ I have a neurological disorder or symptoms like tics, tremors, seizures, problems with my gait □ I get migraines or headaches
□ I have suffered with infertility □ I feel better after a sauna or intense exercise □ I gain weight easily even if I eat right
□ Chronic diseases such as cancer or auto-immune diseases or neurodegenerative or cardio-vascular diseases run in my family

NOS3 (6) ----------

□ My blood pressure is higher than normal (120/80) or high blood pressure runs in my family □ I'm postmenopausal
□ I heal slow after injury/surgery □ I have type 2 diabetes □ I have cold hands or feet □ I get migraines or headaches
□ I have or members of my family have had cardio-vascular disease (including heart attack, atherosclerosis, stokes, …)
□ I suffered from pre-eclampsia while pregnant □ I tend to breathe through my mouth or snore at night or have sinus congestion
□ I smoke □ I live in a city centre □ Congenital birth defects run in my family

PEMT (7)----------

□ I have generalized muscle and joint pain □ I rarely eat leafy green vegetables □ During pregnancy my gall bladder acted up
□ I have queasy liver or fatty liver or it runs in my family □ I have had gall bladder problems or had them removed
□ I have SIBO □ I'm a vegetarian or vegan □ I have been diagnosed with SIBO or I have a lot of bloating □ I'm B12 deficient
□ I eat very little meat or find it difficult to digest fatty foods (eg: beef, organ meat, caviar, eggs, fried foods) □ I'm on antacids
□ I have pain or discomfort or tightness in the upper right hand side of my abdomen or in my right shoulder, by my scapula
□ I tend towards constipation □ I tend to be itchy □ I'm post menopausal