HEALTH APPRAISAL

ADMIN ONLY

Doctor:
Blood Pressure:
Medication:
Tests Ordered:

Tongue:
Nails:
Iridology:
Notes:

Name:
Address:
Phone:
Email:

Health Concerns

Please describe your health condition and concerns:
What is your main ailment:
When did this condition develop:
Do any activities or food make the condition worse?:
Current treatment:
Current medication/supplements:
Please list and date any surgery, fractures, accidents:

Activity Level

Sedentary ◯ Light ◯ Moderate ◯ Athletic ◯

METABOLIC BIOTYPES

Please tick any boxes that are relevant to determine your biotype

	Undermethylation (Histadelia) 22%		Overmethylation (Histapenia) 8%		Pyrroluria (Zinc Depletes) (High H.P.L hydroxyhempyrolin)
	Self motivated (high)		Poor motivation		Poor stress tolerance
	High achiever before illness		Poor achiever		Anxiety/panic/fear
	Strong willed/stubborn/inflexible		Artistic/musical/sculpture		Easily fatigued
	My way/thoughts are correct		High anxiety/panic/nervous		Morning nausea
	Perfectionism/procrastinates		Easily frustrated		Mood swings/instability
	Addictive behaviour (anything)		May stutter		Explosive temper
	High energy (if well)		Fatigue common		Motion sickness
	Obsessional (OCD) (ODD)		Overweight/obesity		Intolerance of annoyances
	Poor compliance		Hirsute/hairy		Irritability
	High libido		Increased dental caries		Sensory (smell, noise, glare)
	Social isolation		Food/chemical sensitivities		Sensitivity
	Easy tearfulness		High pain threshold		Tag cutter
	Collects things		Prone to osteoarthritis		Poor or no dream recall (B6)
	Difficult transitions		Past Hx ADHD		Under-achievement at school
	Walks slowly/motionless		Tinnititus often		Obsessed with smells
	Low pain threshold		Stubby fingers		Fear of plane travel
	Ruminations about the past		Young looking body		Behaviour/learning problems
	Calm demeanour but high inner tension and anxiety		Eczema/dry skin		Violence potential
	Denial of illness		Slow metabolism		Delay/skip breakfast
	Heat intolerant		Better on vegetables		Hate mornings
	Not caring about what people think		Often late		Obsessions about disaster
	Frequent headaches/migraines		Expects perfections in others		Poor short term memory
	Can have severe insomnia but often sleeps less		Concerned by what others think of them		Impulsivity
	Sparse hair growth/slender		REACTS badly to anti-histamines and anti-depressants		Hyperactivity
	prominent veins		Sleep disorder		Denies any problems
	Elongated fingers and toes		Rarely has colds		Food & chemical sensitivities (1:6)
	Fear of failure		Upper body pain		Inability to tan/ pale skin
	Better on animal protein		Restless/nervous legs		Poor growth (low zinc)
	Hears pulse at night		Caring and empathy		Premature greying/ dry skin
	Seasonal allergies		Generous/kind/ loving		Stretch marks (low zinc)
	Fast metabolism		Not keen on sport		Poor muscle development
	Risk-taking		Depression		Acne (low zinc)
	Sudden breakdown		Self mutilation		Severe depression
	Delusions (not external voices) more than hallucinations		Self isolation		Paranoia
	Phobias		Paranoia/less obsessions		Liable mood
	Catatonic/psychosis		Hyperactive psychosis		Long recovery from anger/violent outbursts
	Anorexia/bulimia		Religiosity		Physical acting out
	S.A.D		Grandiosity		Losing control
			Mania		Poor immune function (low zinc)

Medical History

Health History: You and Your Family -any of the following that apply to you or your family-past or present

Condition	You	Family Member/List
Addictions/Alcohol		
Arthritis		
Anxiety/Depression		
Asthma/Bronchitis		
Autoimmune Disease		
Bladder/Kidney		
Bone Loss/ Osteo		
Cancer		
Diabetes		
Digestive/Intestinal Issues		
Ear/Eye Problems		
Eating Disorders		
Genetic Conditions		
Headaches		
Heart Disease		
High Blood Pressure		
HIV/AIDS		
Hormonal Problems		
Hyperactivity/ADHD		
Learning Disability/PDD		
Muscle Problems		
Neurological Problems		
Psychological Problems		
Rheumatic Fever		
Sex Transmitted Diseases		
Seizure Disorders		
Sinus/Respiratory		
Skin Prob/Eczema/Acne		
Stroke		
Thyroid Disease		
Viral Disorders		
Weight Loss/Gain		

Health Appraisal – Brief

0 = Never 1 = Occasionally 2 = Moderate 3 = Severe

PART 1 GASTGROINTESTINAL				
Section A HYPOACIDITY				
Indigestion	0	1	2	3
Belching, burping	0	1	2	3
Gas after eating	0	1	2	3
Sense of fullness during meal	0	1	2	3
Poor appetite, picky eater	0	1	2	3
Difficult bowel movements	0	1	2	3
History of anaemia	N	Y (10)		
Vegetarian- no eggs, dairy	N	Y (5)		
Spoon shaped nails	N	Y (3)		
Unintentional weight loss	N	Y (3)		
Partial loss of taste/smell	N	Y (3)		

TOTAL POINTS_

Section B SMALL INTESTINE/PANCREAS

Indigestion and fullness-lasts 2-4 hours after eating	0	1	2	3
side under rib cage	0	1	2	3
Bloated	0	1	2	3
Excessive passage of gas	0	1	2	3
Abdominal cramps/aches	0	1	2	3
Nausea/and or vomiting	0	1	2	3
Specific foods/beverage –aggravate indigestion	0	1	2	3
Fibre cause constipation	0	1	2	3
Three or more large bowel-per day	0	1	2	3
Alternating constipation- and diarrhoea	0	1	2	3
Undigested food in stool	0	1	2	3
Mucus in stool	0	1	2	3
Dry, flaky skin, brittle hair	N	Y (3)		
Difficulty gaining weight	N	Y (3)		

TOTAL POINTS

Section C HYPERACIDITY				
Stomach pain, burning, aching 1-4 hours after eating	0	1	2	3
Feeling hungry 1 or 2 hours after eating	0	1	2	3
Stomach discomfort, pain in response to strong emotions, thoughts, smell of food	0	1	2	3
Heartburn, especially when lying down or bending forward	0	1	2	3
Heartburn due to spicy food, chocolate, peppers, citrus, alcohol,caffeine	0	1	2	3
Difficulty or pain when swallowing	0	1	2	3
Chest pain or infections	0	1	2	3
Carbonated beverages, cream/milk give temporary relief from symptom	0	1	2	3
Constipation	0	1	2	3
Black, tarry stool	0	1	2	3

TOTAL POINTS

Section D	**COLON**			
Lower abdominal pain cramping or spasms	0	1	2	3
Lower abdominal pain, relief by passing stool or gas	0	1	2	3
Raw fruits, vegetables and stress aggravate bowel pain	0	1	2	3
Diarrhoea (loose watery)	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Painful difficult straining during	0	1	2	3
bowel movements	0	1	2	3
Hard, dry or small stool	0	1	2	3
Feels bowels do not empty completely0	0	1	2	3
Bright red blood following bowel movement	0	1	2	3
Anal itching	0	1	2	3

TOTAL POINTS

PART II **DETOX METABOLISM**

Section A **LIVER/GALLBLADDER/PANCREAS**

Moderate to severe pain under right side of ribcage	0	1	2	3
Abdominal pain worsens with deep breathing	0	1	2	3
Regurgitate bitter food	0	1	2	3
Bloated, feeling full	0	1	2	3
Belching, heartburn, gas	0	1	2	3
Fatty foods cause indigestion	0	1	2	3
Nausea or vomiting	0	1	2	3
Feels restless, agitated, angry	0	1	2	3
Unexplained itchy skin, worse at night	0	1	2	3
Stool colour alternates from clay brown to normal brown	0	1	2	3
Feeling of poor health	0	1	2	3
Fatigue, weakness, exhaustion	0	1	2	3
Unable to concentrate, irritable confused	0	1	2	3
Swollen feet or legs	0	1	2	3
Easy bruising	0	1	2	3
Feeling of extreme dryness	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dark urine, diminished flow	0	1	2	3
Dry flaky skin/hair	0	1	2	3
Yellowish cast to skin, eyes	0	1	2	3

TOTAL POINTS

Section C HYPERACIDITY				
Fatigue, weakness, exhaustion	0	1	2	3
Stomach pain, burning, aching	0	1	2	3
1-4 hours after eating	0	1	2	3
Feeling hungry 1 or 2 hours	0	1	2	3
after eating	0	1	2	3
Stomach discomfort, pain in	0	1	2	3
response to strong emotions,	0	1	2	3
thoughts, smell of food	0	1	2	3
Heartburn, especially when lying	0	1	2	3
down or bending forward	0	1	2	3
Heartburn due to spicy food,	0	1	2	3
chocolate, peppers, citrus, alcohol,	0	1	2	3
caffeine	0	1	2	3
Difficulty or pain when swallowing	0	1	2	3
Chest pain or infections	0	1	2	3
Carbonated beverages, cream/milk	0	1	2	3
give temporary relief from symptom	0	1	2	3
Constipation	0	1	2	3
Black, tarry stool	0	1	2	3

TOTAL POINTS

Section B

HYPOTHYROID

Fatigue, sluggish	0	1	2	3
Feels cold hand, feet	0	1	2	3
Difficult, infrequent bowel movement	0	1	2	3
Dryness skin, hair	0	1	2	3
Thick brittle nails	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Puffy face, hands, feet	0	1	2	3
Swollen upper eyelids	0	1	2	3
Eyeballs move involuntary	0	1	2	3
Muscles weak/cramp, tremble	0	1	2	3
Slow mental processes, forgetful	0	1	2	3
Slow heart beat	0	1	2	3
Loss of appetite	0	1	2	3
Abnormal swelling	0	1	2	3
Unsteady gait movements	0	1	2	3
Lack of interest in sex	0	1	2	3
Premenstrual tension	0	1	2	3
Infertility	0	1	2	3
Heavy menstrual bleeding	0	1	2	3
Gain weight easily	0	1	2	3
Swelling of the neck	0	1	2	3
Thinning hair on scalp, face and genitals	0	1	2	3

PART III	**IMMUNNE**			
Progressive, mild fatigue after exertion or stress	0	1	2	3
General weakness	0	1	2	3
Blurred vision, dizzy when rising	0	1	2	3
Depression	0	1	2	3
Rapid mood swings	0	1	2	3
Irritable, nervous	0	1	2	3
Dark circles under eyes	0	1	2	3
Disinterest in food	0	1	2	3
Abdominal pain	0	1	2	3
Indigestion	0	1	2	3
Blotchy skin (white patches)	0	1	2	3
Tan skin-no sun	0	1	2	3
Black freckles on upper forehead, face or neck	0	1	2	3
Craving for salty food	0	1	2	3
Gradual loss of body hair	N	Y (3)		
Sensitive to minor changes in weather and surroundings	N	Y (5)		

PART IV
MUSCULOSKELETAL

SECTION A BONE DENSITY

Localised bone pain	0	1	2	3
Bone deformity or swelling	0	1	2	3
Shins hurt during or after exercise	0	1	2	3
Low back or hip pain	0	1	2	3
Walking difficulties, limp	0	1	2	3
Crunching or creaking sounds when	0	1	2	3
	0	1	2	3
Hands, feet, throat spasm or numb	0	1	2	3
Joint pain, stiffness, especially	0	1	2	3
spine, hips, knee	0	1	2	3
Hearing loss, headaches, ringing ea	0	1	2	3
Established bone loss	N		Y (10)	3
Calcium deposits	N		Y (6)	3
Spinal curvature	N		Y (10)	3
Recent loss of height	N		Y (10)	3
Bow legs	N		Y (5)	3
Stooped posture	N		Y (5)	3
Hump at base of neck	N		Y (5)	3
Unexplained bone fracture	N		Y (10)	3
Tooth loss, gum disease	N		Y (3)	3

Section B

MUSCLE

Generalised muscle aches and pains	0	1	2	3
Localised muscle stiffness,	0	1	2	3
tension, pain	0	1	2	3
Specific body points feel sore when pressed	0	1	2	3
Headaches	0	1	2	3
Fatigued, tired, sluggish	0	1	2	3
Difficulty sleeping	0	1	2	3
Feel unrefreshed when waking	0	1	2	3
Muscle weakness or loss	0	1	2	3
Difficulty speaking or swallowing	0	1	2	3
Muscle cramps or spasms	0	1	2	3
Muscles twitch or tremble, eyelids,	0	1	2	3
thumb, calf muscle	0	1	2	3
Irresistible urge to move legs	0	1	2	3
Legs move during sleep	0	1	2	3
Numbing, tingling sensation	0	1	2	3
Excessive joint mobility	0	1	2	3
Unable to fully straighten or	0	1	2	3
extend legs or arms	0	1	2	3
Upper or lower back pain	0	1	2	3

Section C CONNECTIVE TISSUE				
Joint stiffness, soreness	0	1	2	3
Red swollen, painful joints	0	1	2	3
Joint stiffness improves with rest,	0	1	2	3
worsens with movement	0	1	2	3
Cracking joints	0	1	2	3
Shooting, aching, tingling pain	0	1	2	3
down the back of leg	0	1	2	3
Joint pain involves one or more	0	1	2	3
joints	0	1	2	3
Joints hurt when moving or when	0	1	2	3
carrying weight	0	1	2	3
Limited range of motion	0	1	2	3
Difficulty standing up from	0	1	2	3
seated position	0	1	2	3
Difficulty chewing food or	0	1	2	3
opening mouth	0	1	2	3
Numbness, prickling, tingling sensation in the neck, shoulder, arm	0	1	2	3
Involuntary muscle spasms	0	1	2	3
Discomfort or pain in neck, shoulder or arm	0	1	2	3
Knobby overgrowths on the joints close to fingertips	N	Y (5)		
Double jointed	N	Y (5)		
One leg shorter than the other	N	Y (5)		

Country wide integrative health - Food & Lifestyle Journal 5 days Date:

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SLEEP PATTERN
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:
					Retire: Rise: Total hrs slept: Basal Temp:

INFORMED CONSENT FORM FOR TREE OF LIFE COMPOUNDING AND WELLNESS CENTRE

I have had the opportunity to discuss with my Natural Therapist named below, the nature and purpose of the recommended natural therapies treatment.

I understand and I am informed that as in all health care in the practice of natural therapies, there may be some slight risks to treatment, including reaction to prescribed Vitamin, Herbal, Homoeopathic remedies and/ or some initial discomfort or reaction to massage or body work procedures.

My practitioner has explained that in many cases this is simply the body adjusting as it makes the changes.

I do not expect my practitioner to be able to anticipate and explain all risks and complications and wish to rely on my therapist to exercise his or her judgement during the course of the prescribed treatment and to make the corrections he/she feels is necessary at the time, based on the facts then known is in my best interest.

I hereby and request and consent to the prescribed course of treatment and procedures by the practitioner named below and that I have had the opportunity to ask questions about treatments.

I intend this consent form to cover the entire course of treatment for my present condition and for any other future condition/s for which I seek treatment.

Print clients name:_____

Client's signature:_____

Date:_____

_____

Witness to the clients signature

_____

Practitioners name: _____

Practitioners address:_____