

Please ensure you use the correct postage i.e. a large stamp. Otherwise there may be a long delay.

Name & Surname:		Date of Birth:	
Address & Postcode:		Telephone:	
Number of children: Ages:	Living circumstances: <input type="checkbox"/> Living with spouse/partner <input type="checkbox"/> Living alone <input type="checkbox"/> Living with family relatives(s)		
Current blood pressure (if known)?	Height: (cm / metres / feet)	Weight: (lbs / kg / stone)	
Job description:			
Reason(s) for completing the questionnaire today:			
Health conditions / symptoms you are seeking support for:		How long has she/he had this?	
	1.		
	2.		
	3.		
Name of GP:			

Please forward my reply:

To my email below (Please print clearly)

Email:

By signing below you are confirming that you have read and understood the Health Questionnaire Terms of Reference attached to this questionnaire (see page 9).

Your Signature..... **Date:**

We will respond to your health questionnaire as soon as possible by post or email; telephone responses are not available. Please note health questionnaire support is not intended to replace a medical consultation or practitioner consultation. If you have health concerns it is important to obtain a medical diagnosis for your symptoms.

Please email your completed health questionnaire to info@alihsaan.co.uk

(Email is not a secure form of communication, Al-Ihsaan will not take responsibility of any loss or damage occurred through email)

If returning by post to us, please mark on the envelope: FAO Dr Y Haffajee. Please note that questionnaires returned **by post may have to wait up to 2 weeks to receive a reply.**

Recent Consultations: Please provide approximate dates and details of any consultations:

Please tick the box next to any of the following that apply to you:

Do you get any severe and/or persistent pain in any of the following:

- | | |
|----------------------------------|---|
| <input type="checkbox"/> Head | <input type="checkbox"/> Eye |
| <input type="checkbox"/> Abdomen | <input type="checkbox"/> Temple |
| <input type="checkbox"/> Chest | <input type="checkbox"/> On passing urine |

Other please write in:

Do you ever get blood in any of the following:

- | | |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Vomit | <input type="checkbox"/> Urine |
| <input type="checkbox"/> Stools | <input type="checkbox"/> Sputum |

Have you recently had any changes in:

- | | | |
|--|---|--|
| <input type="checkbox"/> Level of thirst | <input type="checkbox"/> Weight | <input type="checkbox"/> Appetite |
| <input type="checkbox"/> Skin | <input type="checkbox"/> Vision | <input type="checkbox"/> Bowel movements |
| <input type="checkbox"/> Urination | <input type="checkbox"/> Body/face shape | <input type="checkbox"/> Swallowing |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Personality/ behaviour | |

Your Health History

Have you now or in the past experienced any of the following ? Tick if the answer is **YES**

Condition	Now	Past	Condition	Now	Past
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Ear/eye/nose/throat problems	<input type="checkbox"/>	<input type="checkbox"/>	Drug/alcohol dependence	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Eczema/skin conditions	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart conditions	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual/ menopause problems	<input type="checkbox"/>	<input type="checkbox"/>
Stomach ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>

Urinary tract conditions	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
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Other diagnosed conditions:

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Digestive Function

Do experience the following?	Please provide details of any which occur regularly
<input type="checkbox"/> Abdominal bloating	
<input type="checkbox"/> Acid reflux	
<input type="checkbox"/> Bloating after meals	
<input type="checkbox"/> Burning pains in stomach	
<input type="checkbox"/> Burning pain in throat	
<input type="checkbox"/> Constipation	
<input type="checkbox"/> Diarrhoea	
<input type="checkbox"/> Diverticula	
<input type="checkbox"/> Flatulence belching	
<input type="checkbox"/> Flatulence rectal	
<input type="checkbox"/> Frequent urging to stool	
<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Irritable Bowel syndrome	

Female only: please indicate if monthly menstruation is present: Yes No

Are you prescribed hormonal contraception or hormone replacement therapy? Please provide drug names

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Additional menstrual information:

Are you trying to conceive or currently pregnant?

Surgical procedures: Please provide details of any surgery and approximate dates.

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Prescribed Medicines: Please list all medications you are currently taking and include dose. This information is important to enable us to suggest safe and appropriate nutritional supplements for you. **Please continue on a separate sheet if needed.**

Name of medication	What is it for?	Daily Dose

Non-prescription medications used: Please list any medications, laxatives, herbal products and/or homeopathic remedies that you take on a regular or frequent basis.

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Supplements: Please list all supplements that you are taking currently, dose and brand names:

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.....

Please list any **recently discontinued** medications or supplements?

.....

Family Medical History. Please provide details below of family health conditions. e.g. Angina, Alzheimer's, Arthritis, Asthma, Blood pressure, Cancer, Dementia, Diabetes, Heart disease, Lung disease, Osteoporosis, Parkinson's disease, Stroke.

Parents.....

Grandparents.....

Brothers/Sisters.....

Nutrition and Diet please tick those boxes that relate to your present diet:

- Mixed food diet (animal and vegetable sources)
 - Vegetarian
 - Lacto vegetarian
 - Lacto ovo vegetarian
 - Salt restriction
 - Fat restriction
 - Starch/carbohydrate restriction
 - Calorie restriction
- Other dietary plans, please detail

Food exclusions: please list any foods you **exclude** from your diet. e.g. dairy, eggs, soy, wheat, gluten

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Have you taken any food allergy/intolerance tests? Please state type of test undertaken and results

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Food Frequency:

Fruit: How many portions of fruit do you eat **Each day** Name below those fruits that you eat regularly:

.....

Vegetables: How many portions of vegetables do you eat **Each day** Name below those vegetables that you eat regularly:

.....

How many slices of bread do you eat per week of the following ?

White Wholemeal Granary Rye Wheat free Gluten free

How many portions /week do you eat of the following?

Please insert approximate number.

Pulses, beans, lentils etc..... Beef Lamb Pork Chicken Turkey

Eggs..... Milk Yogurt Cheese White fish Tuna Salmon

Trout Herring Sardines Mackerel

What grains do you eat on a weekly basis? Tick boxes below

- | | | | | | |
|--------------------------------|-------------------------------|-------------------------------------|--|-----------------------------------|--|
| <input type="checkbox"/> Wheat | <input type="checkbox"/> Corn | <input type="checkbox"/> White rice | <input type="checkbox"/> White Pasta | <input type="checkbox"/> Quinoa | <input type="checkbox"/> Millet |
| <input type="checkbox"/> Oats | <input type="checkbox"/> Rye | <input type="checkbox"/> Brown rice | <input type="checkbox"/> Wholemeal pasta | <input type="checkbox"/> Couscous | <input type="checkbox"/> Bulghar wheat |

Eating Habits please tick all of the following which apply.

- skip breakfast
- graze (small frequent meals)
- regularly miss meals
- eat constantly whether or not hungry
- generally eat on the run
- add salt to food
- add sugar to drinks. Number of teaspoons per drink.....

Fluids - Cups per **day** of:

Coffee Tea Green Tea Herb Teas Decaffeinated tea or coffee

Cans/Glasses per **day** of:

Fizzy Drinks Cordial Fruit Juice Sugar free diet drinks Energy Drinks

Water glasses (250ml) per day **OR** litres per day

Other Habits:

Cigarettes **Cigars** Number per day

Alcohol:

Wine 175 ml glasses total per week

Spirits measures total per week

Beer, Lager, Cider, pints total per week

Exercise: How many days per week do you exercise?

- 1-2 days 2-3 days 4-5 days 6-7 days

Duration per session: less than 30 minutes 30-45 mins 45 mins or more

Please describe types of exercise undertaken on a regular basis:

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How motivated are you to change the way you eat and to experiment with new foods?

- I am willing to try anything that might improve my condition
 I feel I can cope with a moderate amount of change
 I feel very anxious about changing my dietary/lifestyle habits

Please rate your motivation on a scale of 0 to 10 (0=low; 10=high):

Food Diary

Please write down all the foods and drinks you consume over a **3** day period, include **1** weekend day.
Please complete as **accurately** and **honestly** as possible.

The following represents my diet for the: last month 6 months plus 1 year plus

Breakfast	Lunch	Dinner	Snacks	Fluids include alcohol
Day 1	Day 1	Day 1	Day 1	Day 1
Day 2	Day 2	Day 2	Day 2	Day 2
Day 3	Day 3	Day 3	Day 3	Day 3

Example

Breakfast	Lunch	Dinner	Snacks	Fluids Include alcohol
Day 1	Day 1	Day 1	Day 1	Day 1

Porridge with honey	Ham sandwich Crisps	Roast Chicken Carrots Peas Mashed potato Apple pie & custard	Crisps Chocolate bar Apple	Tea 4 cups Coffee 1 cup Water 1 glass Red wine 1 glass
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Any additional information you wish to provide may be given below:

HEALTH QUESTIONNAIRE SERVICE – TERMS OF ENGAGEMENT

Health Questionnaire Service: This free service, which is available from our in-house Registered Nutritional Therapist, is offered to our customers as we recognize the importance of diet, lifestyle and choosing appropriate supplements as important to support health improvement. Offering this no obligation service is also in line with our charitable objectives; we are wholly owned by a charitable foundation that supports environmental and health improvement projects globally.

If you complete and return the attached questionnaire, our Registered Nutritional Therapist will send you some written diet and supplement recommendations to support your health goals.

However, please be aware that as a postal questionnaire we are limited in the suggestions and support we can provide.

The Nutritional Therapist requests that the client notes the following:

- The degree of benefit obtainable from the recommendations may vary between clients with similar health problems and following a similar programme.
- Nutritional advice will be tailored to support health conditions and/or health concerns identified on the health questionnaire.
- We are not permitted to diagnose, or claim to treat, medical conditions.
- Nutritional advice is not a substitute for professional medical advice and/or treatment.

The client understands and agrees to the following:

- You are responsible for contacting your GP about any health concerns.
- If you are receiving treatment from your GP or any other medical provider you should tell him/her about any nutritional strategy provided by a Nutritional Therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that you tell your Nutritional Therapist about any medical diagnosis, medication, herbal medicine or food supplements you are taking as this may affect the nutritional programme.
- If you are unclear about the agreed programme / food supplement doses / time period, you should contact your Nutritional Therapist promptly for clarification.
- You must contact your Nutritional Therapist should you wish to continue any specified supplement programme for longer than 3 months, to avoid any potential adverse reactions. In any case we recommend a regular review of supplements to ensure they remain appropriate for your needs.
- You are advised to report any concerns about your programme promptly to your Nutritional Therapist for discussion / action.
- Please note we do recommend that all supplements are taken at different times of the day to any prescribed medications.

We would always recommend you discuss any dietary or supplemental concerns or changes you wish to make with your G.P. Medication should never be discontinued or dosage amended without your G.P.'s prior knowledge and agreement.

I understand the above and agree that the health questionnaire service provided by Cytoplan Ltd will be based on the content of this document. We declare that all the information we share on this health questionnaire is confidential and, to the best of our knowledge, true and correct.

Name of client: Client Signature:.....

Date:.....