



PRE TREATMENT QUESTIONNAIRE

PERSONAL DETAILS

Full Name

Address

Date of Birth

Age

DIET & LIFESTYLE

Breakfast

Lunch

Dinner

Snacks / Sugar Cravings

Do you drink Alcohol? Yes No If yes, how much?

DIGESTIVE HEALTH

Bowel patterns - how many times per day?

Shape / consistency?

Easy to pass? Yes No

Any bouts of constipation or diarrhoea? Please describe.

STRESS & SLEEP

Stress Level (0 = none, 10 = extreme)

Main Stressors

Describe your sleep - easy to get to sleep, stay asleep, any night waking (what time), wake feeling refreshed?

MENSTRUAL CYCLE

How often is your cycle?

Flow (light / moderate / heavy)?

Any pain? Yes No If yes please describe.

MEDICAL HISTORY

Are you currently taking any medication? Yes No If yes, please list.

Vaccines received in the last 5 years?

Any Operations of Injuries? Please describe.

Any known allergies?

SUPPLEMENTS & SELF CARE

Are you taking any supplements? Yes No If yes, please list.

Do you have a self care routine? (meditation, yoga, time in nature)

DECLARATION

I confirm the information above is accurate to the best of my knowledge.

Signature

Date