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| |  | | --- | | Julia K M Fuchs (KFRP) Food & Allergy Testing  Patient Form –  *Private and Confidential* | | | |
| Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Parent Name, if applicable:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |  | |
| DOB: | Address: | | |
| Phone/s: | Email Address: | | |
| Profession: | How long and how often do you usually work? | | |

|  |  |
| --- | --- |
| Do you have any children? If so, please state age and sex |  |
| Are there any illnesses your children suffer from? |  |
| Which illnesses run in your family?  Mother: |  |
| Father: |  |

What would you like to get out of your session with me?

Main health issues you would like to address in order of priority

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| 1 | 2 | 3 |

Please list what you normally eat for

* Breakfast:

* Lunch:

* Tea:
* Dinner:

Snacks:

Drinks:

Please indicate the amount you consume per day of the following:

|  |  |  |  |
| --- | --- | --- | --- |
| Cups of tea |  | Cups of coffee |  |
| Portions of vegetables |  | Portions of fruit |  |
| Teaspoons of sugar |  | Alcohol units |  |
| Glasses of water |  | Cigarettes |  |

Do you/did you have amalgam (silver)fillings, piercings or tattoos?

Do you react to costume jewelry, watches, jeans studs?

Candida self-assessment score: \_\_\_\_

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| Do you have food intolerances? Please list |  |
| Please give a description of the symptoms |  |
| Do you suffer from allergies? Please list |  |
| Please give a description of the symptoms |  |

Please tick any of the following symptoms you experience often:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Acne |  | Asthma |  | Eczema |  |
| Psoriasis |  | Skin rashes |  | Thrush |  |
| PMS/heavy painful periods |  | Headaches/migraines |  | Irritability/Restlessness |  |
| Dizziness |  | Stomach pains/ulcers |  | Dyslexia/Stammering |  |
| Colds |  | Infections |  | Joint Pain/Arthritis |  |
| Cold hands/feet |  | Neck/back pain |  | Bloating /flatulence |  |
| Depression |  | Indigestion |  | Poor memory |  |
| Muscle aches/Rheumatism |  | Constipation/loose bowels |  | Anxiety/Tension |  |
| Mood swings |  | Lack of energy |  | Low libido |  |

Are you receiving any medical treatment? If so, what treatment?

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Are you seeing any other therapists at the moment? If so, which therapist?

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Do you take any medication? Please list the name and the dosage:

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Please list any supplements you take, including the dosage:

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**Please bring all your medication, supplements and, in case you are consulting me regarding a skin disorder, your skincare products with you!**

In which situation have you been in at the time of the onset of your illness, including family, work and environment?

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Please add any additional information, or any other symptoms, even if they don’t seem relevant to your health problem:

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How did you find out about my services and/or who recommended you?

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*I appreciate that Natural Healthcare Practitioners do not give medical diagnosis or treatment. I understand that my GP and I are responsible for the medical care of myself and/or my dependants.*

|  |  |
| --- | --- |
| Signed | Date |

*I understand that I will have to cancel my session within 24 hours prior to my appointed time. If I fail to do so I agree to pay half the consultation fee.*

|  |  |
| --- | --- |
| Signed | Date |