a:d anyadutton

# Pre-Consultation Form

Pls fill in before the consultation

©Anya Dutton (nee Wegner) Dipl Nat Nut BANT NNA

## Personal information

| | |
|---|---|
| **Name:** | **Date:** |
| **Date of birth:** | **Sex:** **Male / Female** |
| **Full postal address:** | |
| **Preferred contact telephone number(s):** May we leave voice-mail messages related to your visits? **Yes / No** | |
| **Email address:** May we send clinic-related information to your mailing/email address? **Yes / No** | |
| **Emergency contact:** We are required to ask you for an emergency contact.<br>**Name:**<br>**Phone number(s):**<br>**Relationship to you:** | |
| **Your height:** | **Your weight:** |

## Reasons for consulting

**List your primary health concerns.**

*Pls continue overleaf if necessary.*

## Your health & your medical history

**How would you describe your overall state of health?** (circle)

**Very poor** **Poor** **Fair** **Good** **Very good** **Excellent**

**Medical history** **(List past medical conditions, diagnoses received, accidents, injuries, surgeries, past illnesses...CONTINUE ON SEPARATE SHEETS where necessary. The more information the better – the smallest thing may be of significance)**

*Pls continue overleaf if necessary.*

**List any known allergies:**

*Pls continue overleaf if necessary.*

**Name and address of your GP?** (Note: we will not contact your GP without your consent.)

**List any other treatments you are currently receiving,** e.g. Chemo/Radiotherapy, Chiropractic, Acupuncture, Herbal, Physiotherapy, Massage, Reiki…

*Pls continue overleaf if necessary.*

**Do you have Amalgam (mercury) fillings** – if yes, how many?

**Have you had root canal treatment?** – if yes, how many teeth affected?



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## CONDITION CHECK

Please tick any condition in the table below that has applied to **you** yourself (1st column) or to **parents, grandparents or siblings** within your **blood family** (2nd column). If you do not know, do not tick. **For family consultations:** Parents should fill in both columns for themselves and for each child fill in the 'you' column.

| You | Fam | | You | Fam | | You | Fam | | You | Fam | | You | Fam | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Hairloss | | | Hayfever | | | Loss of memory | | | Palpitations | | | Shoulder or neckpain |
| | | Dizziness | | | Fainting | | | Brittle bones | | | Psoriasis | | | Vegetarianism/Veganism |
| | | High alcohol consumption | | | Sinus issues (any) / sinusitis | | | Loss of feeling in feet or hands | | | Hepatitis or any other liver disease | | | Lessened sensation in toes or fingers |
| | | Vaginal discharge | | | Otitis (ear infection) | | | Easy bruising | | | Speech problems | | | Rheumatic fever |
| | | Stress | | | Tumour (any) | | | Warts | | | Repeated dieting | | | Crohns or Ulcerative Colitis |
| | | Dandruff | | | Kidney disease | | | Skin changes (any) | | | Tuberculosis (TB) | | | Phobias, panic attacks |
| | | Abscess (any) | | | Infertility | | | Hives | | | Mood changes | | | Malaria |
| | | Impotence | | | Jaundice | | | Haemorrhoids | | | Diabetes | | | Frequent headaches |
| | | Genital itching | | | Glasses/ contact lens | | | Weakening sight | | | High blood pressure | | | Night sweats |
| | | Heart disease | | | Impaired hearing | | | High blood sugar | | | Persistent backache | | | Breast lumps / cysts |
| | | Asthma | | | Eczema | | | Gluten sensitivity | | | Epstein Barr Virus | | | Mononucleosis |
| | | Swollen glands | | | Acne (child or adult) | | | Arthritis | | | Swollen legs | | | Abcess |
| | | Anaemia | | | Migraines | | | Smoking (all types) | | | Sciatica | | | Unexplained pains (any) |
| | | 'Recreational' drugs (any type) | | | Restless Legs syndrome | | | Sexually transmitted diseases (any) | | | Hormonal issues of any kind | | | Circulatory problems (veins, arteries, heart) |
| | | Loss of balance | | | Emphysema | | | Incontinence | | | Athlete's foot | | | Herpes virus (any) |
| | | Insomnia | | | Osteoporosis | | | Intestinal parasites | | | Nasal obs tructions | | | Carpal tunnel syndrome |
| | | Candida | | | Glaucoma | | | Arthritis | | | Fibromyalgia | | | Celiac disease |
| | | Bone deformities | | | Autistic spectrum | | | Fungal infections (any) | | | Thyroid problems | | | Memory issues (any) |
| | | Tropical illness (any) | | | Cystitis | | | Lactose intolerance | | | Flatulence | | | Gum disease |
| | | Constipation | | | Shingles | | | Anal itching | | | Periods of coughing | | | Auto-immune disease (any) |
| | | Endometriosis | | | Polyps | | | Pneumonia | | | Heartburn | | | Men: Prostate problems |
| | | Depression | | | Unsteady on legs | | | Rapid / irregular pulse | | | Rickets | | | Mental illness |
| | | Skin allergies | | | Hearing loss | | | Anxiety | | | Paralysis | | | Frequent sprains |
| | | High cholesterol | | | Cataract | | | Cold sores | | | Skin disease (any) | | | Stroke or ministroke |
| | | Aneurysm | | | Food poisoning | | | Heart attack | | | Glandular fever | | | Shaking / tremor any kind |
| | | Tendonitis | | | Joint pain | | | Eating disorder | | | Irregular heart beat | | | Cirrhosis of the liver |
| | | Tick bite | | | Blackouts | | | Eye disease (any) | | | Fibroids | | | UTI Urinary Tract infections |
| | | Stress related issues | | | Epilepsy | | | Caries, tooth decay | | | Hot flushes | | | Gall bladder removed |
| | | Virus (any) past/pres. | | | Weight Issues | | | Polycystic ovary syn. | | | Polycystic kidney dis. | | | Changes in appetite |
| | | Joint hypermobility | | | Menstrual issues | | | Skin rashes (any) | | | Shortness of breath | | | Low blood pressure |
| | | Varicose / Spider veins | | | Chest pain | | | Cancer (any type) | | | Bone pain | | | Congestive heart failure / enlarged heart |
| | | Heart murmur | | | Glandular fever | | | Meningitis | | | Wheezing | | | |

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Bloating, gas, IBS | | | Kidney stone(s) | | | Stomach ulcer | | | Strepthroat | | | Oedema / water retention |
| | | Sleep troubles (any) | | | Bronchitis | | | Goiter | | | Broken bone(s) | | | Alzheimer's or dementia |
| | | AIDS / HIV | | | Pancreatitis | | | Seizures or convulsions | | | Halitosis (bad breath) | | | Unusual or changing moles |
| | | Lung disease (any) | | | Gout | | | Gall stone(s) | | | Chronic Fatigue Syndr. | | | Unexplained weightloss |

## SIGNS & SYMPTOMS CHECK

Please tick anything that does currently or has in the past applied to you.

| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Feeling dizzy when getting up suddenly | | Hands change colour in cold, cold extremities | | Passing dry / hard / painful stools | | Undigested food / can observe bits in stool | | One-off pains in arm or chest (however minor) |
| | Calf, foot, toe cramps at rest | | Dark or strong smelling urine | | Pain in mid back region | | Not tolerate caffeine / coffee | | Hate high temperatures |
| | No appetite for breakfast | | Mouth ulcers / sores | | Blood in urine or in the stool | | Trouble or pain urinating | | Frequent stumbling |
| | Tingling feeling | | Loss of smell /taste | | Difficulty swallowing | | Palpitations | | Clubbing of nails |
| | Use of Antihistamines / anti allergy drugs / inhalers | | Use of Aspirin or blood thinning medication | | Reaction to wine (but not to other alcohols) | | Use of Statin drugs / lowering cholesterol drugs | | Problems with speech or finding words |
| | Burping | | Darker skin patches | | Difficulty seeing at night | | Crave salty foods | | Antibiotic use past/present |
| | Muscle twitching, e.g. eyelid twitching | | Tick if you were born by CESARIAN | | Tick if you were in hospital during your first 2 years in life | | Use of Antacids, stomach liners (any) | | Needing to go to the toilet during the night |
| | Tick if you were NOT breastfed | | Cold sweats | | Frequently sunburnt | | Skincrawling sensation | | Heavy metal poisoning |
| | Nausea or stomach upset after eating fatty meal | | Afternoon yawning or afternoon headaches | | Lower back pain that worsens when fatigued or worn out | | Waking suddenly at night gasping for air | | Nails or the white of the eyes having a bluish tint |
| | Feeling nauseous in morning | | More than 2 colds per year | | Flushing easily | | Clotting in period blood | | Unexplained forgetfulness |
| | The white of the eyes appearing yellow or red | | Dripping down the back of the throat ("postnasal drip") | | Greasy or fatty looking, shiny stools | | Motion sick when travelling by car, air or boat | | Dry skin, itchy feet, or skin peels on feet |
| | Persistent runny nose | | Pain between shoulder blades | | History of morning sickness | | Light 'clay' coloured stools | | Headaches above the eyes |
| | Gallbladder attacks | | Bitter taste in mouth | | Easily intoxicated by alchohol | | Dry skin | | Fatigue beyond normal |
| | Very sensitive to smells (perfume, exhaust fumes etc.) | | Pain under right side of rib cage | | Longterm use of prescription medication (ANY) | | Hangover after drinking small amounts of alcohol | | Less than 1 bowel movement a day |
| | Abdomen Bloats after meals | | Pulse speeds up after eating | | Craving bread, pasta, pizza, … | | Diuretic drugs ("water pills") | | Heavily coated tongue |
| | Overeating, undereating | | Suspected wheat /dairy issues | | Unusual sweating | | Dark circles under eyes | | Mucus in stool |
| | Getting out of breath when climbing stairs | | Slow to wake up, alert at night, trouble falling asleep | | Cold sores, fever blisters, herpes lesions | | Tick if aspirin is an effective painkiller for you | | Feeling shaky if meals are delayed |
| | Difficult to stop flow of urine | | White spots on fingernails | | Ridges on fingernails | | Use of birth control pills | | Nose bleeds |
| | Frequent thirst or urination | | You are "the worrying type" | | Small bumps on back of arm | | Daytime sleepiness | | Craving chocolate |
| | Eyes sensitive to strong light | | Excessive hairloss | | Seasonal sadness | | Coughing at night or when lying down | | Muscle cramps or spasms |
| | Nail problems (any) | | Poor appetite | | Muscle weakness or stiffness | | | | Digestive issues (any) |

Are there any **other conditions or symptoms** not mentioned above that you think I should be made aware of? (please list)

**Which childhood illnesses have you had?** (please circle)

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Mumps | Measles | Rubella | Chickenpox | Glue ear | Polio | Whooping cough = Pertussis | Scarlet fever | Other |

**Which vaccinations have you had?** (please circle)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| MMR (Mumps, measless, rubella) | Smallpox | DPT (diphtheria, pertussis, tetanus) | Tetanus booster (when last?) | Influenza (when last?) | Hepatitis A or B | Polio | Other (name) |

**Have you ever travelled outside Europe?** (list destinations)

| |
|---|
| |

**Approx. date of your last blood test:**

| | |
|---|---|
| | Were all values within the ranges considered normal? **Yes / No** |

**Do you know your…:** (specify values where known)

| | | | |
|---|---|---|---|
| **Blood pressure**? | **Blood sugar**? | **Cholesterol level**? | **BMI?** |

## Medication/supplement use

**List present and past medications** (prescription as well as over-the-counter meds.) You must give the dosage for PRESENT meds.

*Pls continue overleaf if necessary.*

**List supplements** (with brandnames where known). You must give dosages for those you take currently.

*Pls continue overleaf if necessary.*

**Frequency of antibiotic use** (circle)

| | |
|---|---|
| **once in 5 years – once a year – more frequently** | |
| **Have you ever taken probiotics? Yes / No** | **When last and which brand(s)?** |

## Nutrition

**Describe a typical day's food and drink intake. Pls include time.**

| *Time* | *Description* |
|---|---|
| *Example:* 0730 | Glass semi skimmed milk w/ oats and cornflakes (Kellogg's), 1tbspoon sugar (white). 1 yoghurt full fat dairy. 1 banana, handful of dried raisins. 1 mug coffee w/ milk and 2 teaspoon sugar. |
| | *Pls continue overleaf if necessary.* |

**Do you have any dietary restrictions?** (E.g. vegan, religious, dairy-free,…)

**How much water/herbal tea do you drink each day?** (Coffee/non-herbal tea do not count)

## Lifestyle

| | | |
|---|---|---|
| **What is your job?** | **How do you feel about your job?** | |
| **Rate your stress levels out of 10:** (10=max) | **How well do you handle stress?** | |
| **Is your homelife…:** (circle) **Stressful - Mildly Stressful - Neutral - Happy** | | |
| **Do you feel that something can/could be done about the stressors in your life? Yes / No** | | |
| **Rate your energy levels out of 10:** (10=max) | | |
| **What do you do to relax, for "me-time"?** | | |
| **How often do you take "me-time"?** | **How often do you exercise?** | |
| **What type of exercise?** (List) | | |
| **How many hours of TV do you watch a week?** | **Do you have a TV in yr bedroom?** | **… a PC?** |
| **Rate how well you sleep out of 10:** (10=max) | **How many hours of sleep do you get?** | |

## Environment & toxins

**Pls circle anything that pertains to your life.** (Whatever the frequency of use. This form is 100% confidential.)

| | | | |
|---|---|---|---|
| Active or passive smoking | Soda / fizzy drinks (all types) | Alcohol | Coffee |
| Antihistamines | Relaxation or sleeping aids | Appetite suppressants | Recreational drugs |
| Swimming pool | Sleep with mobile near bed | Antidepressants | Diet supplements (any) |
| Decaffeinated drinks | Margarine, soft butter spreads | Hair dyes (home or salon) | Tap water |
| Deodorant with aluminium *(Note: unless it says otherwise, all deodorants contain aluminium)* | | | Pesticides |
| Black teas (i.e. non-herbal) | Fungus in walls (home/work) | "Uppers"/stimulants | Nail varnish & remover |
| Energy drinks (e.g. *Red Bull*) | Fluoride toothpaste/mouthwash | Sugar, syrup | Chewing gum |
| Drain cleaner | Varnish/non-water based paint | Air fresheners home/car | Anti-anxiety drugs |
| Perfume/aftershave | Contact with bleach | Walking/cycling in city traffic | Fish more than 3x a week |
| Antacids (acid reflux meds.) | Use of aspirin or ibuprofen | Coldsore cream, Zovirax | Plastic bottled drinks |
| Red meat | Cough medicine | Fruit juices (not home made) | Sweets/cakes/chocolate |
| Face and/or body creams | Artificial sweeteners (any kind) | Tooth whitening (incl. dentist) | False nails |
| Tinned/canned foods | Solvents of any kind | Laundromat/laundrette use | Asbestos |
| Contact with animals (any) | Milk products | Ice cream | Fried foods |
| Sweet tooth | Baked goods (bread, cakes..) | Pasta, pizza | Use of steroid drugs |
| Chewing tobacco | Sliced meats/lunchon meats | Antifungal drugs/sprays | Diabetes drugs |
| Oral or vaginal contraceptive | Use of laxative however frequent | Hormone replacement therapy | Beta blockers |
| Non-organic tampons | Non-organic skin/hair care | Non-organic vegetables | Inhalers |
| New mattress last 2 years | New carpet last 2 years | Hairspray | Vaseline or non-organic lipbalm |
| Electric cigarettes | Nicotine patches | Sitting near printer or photocopier home/work | |
| Field or verge near home is pesticide treated /sprayed | Cooking oils other than olive oil or coconut oil | | Non-organic eggs |
| | | Wifi source nearby | Mobile phone mast nearby |

## Statement of Acknowledgement and Informed Consent to Examination and Treatment

By signing this statement of acknowledgement, you understand that:

1. I view my practice as a Naturopathic Nutritionist as a complement, not as a replacement, to any conventional medical treatment you may currently undergo. I recommend that you DO NOT CEASE any medical treatment you are currently following. I recommend that you consult a doctor/GP/hospital for any symptoms. A consultation with me does not replace a visit to your GP or hospital. If you are uncomfortable seeing a GP please phone the NHS helpline on **0845 4647 (24 hours)**.
2. Any methods I may use have a proven clinical foundation, yet they may not be recognized or accepted by all representatives of traditional (allopathic) medicine.
3. I am required by my licensing board to take each new patient through a full consultation and intake form. I am required to refer for symptoms which could potentially be linked to dangerous conditions ("red flags"). Any suggestions or referrals I will make are based on the assessment of your health, revealed through the personal history and symptoms which you share with me, in addition to laboratory testing and any other appropriate method of evaluation. I reserve the right to determine which cases fall outside my scope of practice, in which event I will refer as appropriate.
4. You are seeing me, and you are accepting or rejecting my suggestions of your own free will.
5. The ultimate responsibility for your healthcare is your own and I am here to support you in any steps you want to take to improve your health. Improvements are conditional upon you taking steps & continuously following a path to better health.
6. All fees, for services and supplements are payable at the time of appointment by the patient or the guardian. There is a fee for completing insurance forms, letter writing, and telephone consultations up to 15 minutes.
7. Notice of 24 hours is required for appointment cancellations, otherwise you will be charged an administration fee of 35.00 pounds plus travel cost where applicable. Special financial arrangements have to be made clear in writing in advance.
8. Even the gentlest of therapies and supplements may have their complications under certain physiological conditions and hence the information provided is based on the information you have provided to me.
9. You are not an agent of any private or government agency, or a nutritionist or alternative therapist, trying to gather information without stating your intentions.
10. Please note that any handouts or documents I may give you are specific to your case and should not be distributed even to friends and family. Much harm can be done by giving inappropriate advice. Also, all my material is copyrighted.

I acknowledge that I have read and understood the above and herewith give my informed consent.

**Name** (write in full)**:** **Date:**

**Signature:**