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. **Name:** **Phone number(s):** **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?

www.anyadutton.com anyadutton@gmail.com

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						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 / 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: