real food
real weightloss

Your details:	
Name: Address: Contact number: Date of birth:	
Do you have a past history of:	**YES/NO**
Diabetes, including diabetes in pregnancy/blood sugar problems in pregnancy	
Thyroid disorder	
High blood pressure	
Gall bladder disease or biliary colic	
Pain or nausea after eating fatty foods	
Gout	
History of depression requiring medication	
Operations	
Cancer of any type	
Hay fever or blocked nose	
Do you use nasal sprays?	
Comments on any above symptoms?	
Current symptoms:	**YES/NO**
Bowels open daily?	
Constipation in the past?	
Any abdominal pain at present?	
Any bleeding from the bowel?	

Any antibiotics in the last 2 years?	
Have you ever been diagnosed with a Leaky Gut by a naturopath or doctor?	
Comments on any above symptoms?	
Have you had a blood test in the last 6-12 months? If yes, please either provide a copy of these results if you have access to them OR advise which pathology company you had this test with?	
Stress levels - how stressful is life at the moment? (please tick):	
☐ Low ☐ Medium ☐ High	
Energy levels (Please tick):	
☐ Low ☐ Ok ☐ Great	
Sleep pattern:	**YES/NO**
Snoring?	
Difficulty getting to sleep	
Early morning waking?	
Falling asleep during the day?	
For Women only:	
Start of Last menstrual period? Using contraception? Any hormonal treatments, including bio-identical hormones? History of Polycystic Ovarian Syndrome?	

Past history of ruptured ovarian cysts?

History of Pruritus (severe itching) during pregnancy?

Are you going through menopause?

Medication (please list your current medication):

Do you exercise?

☐ YES

☐ NO

If yes what kind of exercise and how often?

Do you smoke?

☐ YES

☐ NO

If yes, how many per day?

Do you drink Alcohol?

If YES, what type? (Please tick):

☐ Beer

☐ Cans or bottled mixers
(eg: Vodka coolers etc.)

☐ Red Wine

☐ White wine

☐ Spirits

How many glasses per day?

How many days per week?

Current Weight :

What is your heaviest ever weight?

Have you tried to lose weight before?

(IF YES)What program/weight loss strategy did you try?

How long were you on it?

Do you remember feeling hungry during previous weight loss programs?

How much weight did you lose?

How long did you maintain the weight lost?

Do you have a goal weight in mind?

What's your motivation for losing weight? For example:

- ☐ For general health
- ☐ For family
- ☐ For self esteem
- ☐ Because of a medical condition (Diabetes, OA knees, Sleep apnoea etc.)
- ☐ My doctor told me too
- ☐ Other (Please specify)