

CHRISTIAN BATES HEALTH ASSESSMENT INTAKE FORM

Date:

Name:

Answer all symptoms as they have been over the last 30 days or since you last filled out this form, which ever was most recent. Simply cross or fill in the appropriate score for each symptom. Use the following scale:

- 1 2 3 4 No symptoms at all
- 0 1 2 3 4 Suffer occasionally / mild
- 0 1 2 3 4 Suffer often / moderate
- 0 1 2 3 4 Stuffy often / severe
- 0 1 2 3 4 Suffer frequently / severe

Nasal / sinus

- 0 1 2 3 4 Post nasal drip
- 0 1 2 3 4 Sinus pain
- 0 1 2 3 4 Runny nose
- 0 1 2 3 4 Stuffy nose
- 0 1 2 3 4 Sneezing

Lungs

- 0 1 2 3 4 Congestion
- 0 1 2 3 4 Asthma
- 0 1 2 3 4 Wheezing
- 0 1 2 3 4 Chronic cough
- 0 1 2 3 4 Shortness of breath
- 0 1 2 3 4 Cough up phlegm
- 0 1 2 3 4 Smoker
- 0 1 2 3 4 Shallow breather

Musculoskeletal

- 0 1 2 3 4 Joint pains
- 0 1 2 3 4 Stiff joints
- 0 1 2 3 4 Arthritis
- 0 1 2 3 4 Osteoporosis
- 0 1 2 3 4 Receding gums
- 0 1 2 3 4

Mind

- 0 1 2 3 4 Poor memory
- 0 1 2 3 4 Confusion, poor comprehension
- 0 1 2 3 4 Poor concentration
- 0 1 2 3 4 Slurred speech
- 0 1 2 3 4 Learning difficulties

Head / ears

- 0 1 2 3 4 Headaches
- 0 1 2 3 4 Migraines
- 0 1 2 3 4 Earache
- 0 1 2 3 4 Ear infection
- 0 1 2 3 4 Itchy ears
- 0 1 2 3 4 Ringing ears

Skin

- 0 1 2 3 4 Acne
- 0 1 2 3 4 Eczema
- 0 1 2 3 4 Psoriasis
- 0 1 2 3 4 Rashes / hives
- 0 1 2 3 4 Excessive sweating
- 0 1 2 3 4

Cardio-vascular

- 0 1 2 3 4 Palpitations
- 0 1 2 3 4 High blood pressure
- 0 1 2 3 4 Breathlessness
- 0 1 2 3 4 Poor circulation
- 0 1 2 3 4

Genito-urinary

- 0 1 2 3 4 Increased frequency
- 0 1 2 3 4 Painful urination
- 0 1 2 3 4 Previous infections / cystitis
- 0 1 2 3 4 Need to go at night
- 0 1 2 3 4 Difficulty starting / stopping
- 0 1 2 3 4 Rarely needs to urinate
- 0 1 2 3 4 Frequent urges to urinate

Weight

- 0 1 2 3 4 Overweight
- 0 1 2 3 4 Underweight
- 0 1 2 3 4 Gain weight easily
- 0 1 2 3 4 Difficult to lose weight
- 0 1 2 3 4 Dieting hasn't worked
- 0 1 2 3 4 Exercise doesn't help
- 0 1 2 3 4 Weight gain around hips
- 0 1 2 3 4 Weight gain around abdomen
- 0 1 2 3 4 Weight gain all over

Digestion

- 0 1 2 3 4 Bloating
- 0 1 2 3 4 Diarrhea
- 0 1 2 3 4 Constipation
- 0 1 2 3 4 Heartburn / reflux
- 0 1 2 3 4 Indigestion
- 0 1 2 3 4 Intestinal cramps / pain
- 0 1 2 3 4 Excess belching / burping
- 0 1 2 3 4 Gas, bottom end / flatulence
- 0 1 2 3 4 Nausea vomiting
- 0 1 2 3 4 Bad breath
- 0 1 2 3 4 Coated tongue
- 0 1 2 3 4 Have pets eg cats, dogs, farm animals
- 0 1 2 3 4 International travel

Dental

- 0 1 2 3 4 Fillings
- 0 1 2 3 4 Mercury fillings
- 0 1 2 3 4 Root canals
- 0 1 2 3 4 Frequent infections
- 0 1 2 3 4 Other dental work

Women / hormones

- 0 1 2 3 4 Irregular periods
- 0 1 2 3 4 Painful periods
- 0 1 2 3 4 Heavy periods
- 0 1 2 3 4 Long term contraceptive pill
- 0 1 2 3 4 PMT / PMS / mood swings
- 0 1 2 3 4 Menopause / hot flushes
- 0 1 2 3 4 Dark blood clots

Thyroid

- 0 1 2 3 4 Tired / sluggish
- 0 1 2 3 4 Hair loss
- 0 1 2 3 4 Miscarriages
- 0 1 2 3 4 Infertility
- 0 1 2 3 4 Cold hands and feet
- 0 1 2 3 4 Gains weight easily
- 0 1 2 3 4 Flush easily

Dominant emotions

- 0 1 2 3 4 Anger / aggressiveness
- 0 1 2 3 4 Anxiety / nervousness
- 0 1 2 3 4 Depression
- 0 1 2 3 4 Fear
- 0 1 2 3 4 Mood swings
- 0 1 2 3 4 Joy
- 0 1 2 3 4 Worry
- 0 1 2 3 4

Food



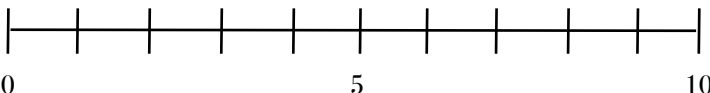


- 0 1 2 3 4 Shaky / faint if hungry
- 0 1 2 3 4 Palpitations if hungry
- 0 1 2 3 4 Awaken in early hours of morning
- 0 1 2 3 4 Hard to get back to sleep
- 0 1 2 3 4 Need coffee, chocolate or sweets when tired
- 0 1 2 3 4 Craves sweets
- 0 1 2 3 4 Thirsty much of time
- 0 1 2 3 4 Diabetes in family history
- 0 1 2 3 4 Are vegetarian / vegan

Stress / adrenals

- 0 1 2 3 4 Significant stress / emotional issues
- 0 1 2 3 4 Crave salt
- 0 1 2 3 4 Always tired
- 0 1 2 3 4 Long time to wake in morning
- 0 1 2 3 4 Lightheaded or dizzy, especially on rising from sitting or lying
- 0 1 2 3 4 Irritable / nervous stomach
- 0 1 2 3 4 Anxiety / nervousness / depression
- 0 1 2 3 4 Decreased sex drive
- 0 1 2 3 4 My tolerance has decreased
- 0 1 2 3 4 Colds last longer than a week
- 0 1 2 3 4 Chronic fatigue
- 0 1 2 3 4 Allergies
- 0 1 2 3 4 Sensitive to bright lights

List your top three or more conditions that you would like to get rid off:

- 1.
- 2.
- 3.
- 4.
- 5.

	Grade how well you sleep	Very poorly
Very well		
	Grade your stress levels at work	Highly stressed
No stress		
	Grade your stress levels outside of work	Highly stressed
No stress		
	How often do you exercise?	Daily exercise
Never		
	Do you relax, meditate, visualise quietly?	Daily relaxation
Never		

The foods you eat:

On average how many times do you eat / drink the following per day or week, or enter in your own frequency i.e. coffee, twice per week

Are you vegetarian?	Yes / No
Glasses of water	Per day:
Coffee / tea	Per day:
Red meat	Per week:
Pieces of fruit	Per day:
Portions of vegetables	Per day:
Chicken portions	Per week:
Oily fish	Per week:
Glasses of Milk	Per week:
Wheat bread / pasta	Per week:
Portions of cheese	Per week:
Sugar, cakes, fizzy drinks	Per week:
Units of alcohol	Per week:
Meals out of a packet	Per week: