PAUL K **EHREN**

Health, Exercise & Nutrition Consultant

PKE HEALTH QUESTIONNAIRE

paulkehren.co.uk

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PERSONAL DETAILS

Name **Date of Birth**

Height **Weight**

Marital Status **No of children**

Occupation – does this involve shift work?

Address

Telephone Number
Email
Goals or reason(s) for seeking advice

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PERSONAL & FAMILY HEALTH

Name and address of GP

Please list any significant current or previous medical conditions

Please list any current medications (under prescription or not)

Health status of blood relatives:

Father
Mother
Brother(s)
Sister(s)

Do you:
Smoke?
Drink alcohol?
Use recreational drugs?

Read the following and fill in the number that applies. Or answer yes/no where appropriate

0 – the symptoms do not occur
1 – the symptoms are mild or rarely occur (once a month or less)
2 – the symptoms are moderate or occasionally occur (weekly)
3 – the symptoms are severe or frequently occur (daily)

Mood

Aggression or anger
Depression
Mood swings
Anxiety
Hyperactive
Panic attacks

Digestion

Belching or gas within 1 hour of eating
Bloating after eating
Diarrhoea after eating
Bloody or Black stool
Heartburn or acid reflux
Stomach pains or cramps
Diarrhoea – Chronic
Constipation

How many times per day/week do you have a bowel movement?

Sleep

Difficulty getting to sleep
Poor quality sleep
Constantly tired
Difficulty waking up
Shift work
Excessive sleep

Immune system

Constant colds or minor ailments – yes/no

Rarely get sun exposure – yes/no
Recent or regular Antibiotic use – yes/no

Thrush/fungal nail/athlete's foot – yes/no

"Run-down" during winter months – yes/no
Allergies – yes/no
Eczema/psoriasis/dry skin – yes/no

Female profile

Do use the contraceptive pill or IUD – yes/no
Any symptoms of menopause – yes/no
Have you undergone HRT – yes/no
Severe PMS symptoms – yes/no

Are your periods normal/regular – yes/no
Excessive hair growth/acne – yes/no
Hysterectomy or other surgery – yes/no
Botox/fillers etc – yes/no

Male profile

Difficulty urinating – yes/no
Urinate often at night – yes/no
Discoloured/bloody urine – yes/no

interrupted urine flow – yes/no
painful urination – yes/no
Erectile problems – yes/no

Do you suffer or have you suffered from:

Frequent thirst or urge to urinate – yes/no
Dizziness when hungry – yes/no

Constantly Cold hands/feet – yes/no
Glandular fever – yes/no
Stroke – yes/no
Epilepsy – yes/no

Raised cholesterol/triglycerides – yes/no
Liver or kidney condition – yes/no
Injury to head, neck, back, knees, ankles – yes/no

Craving for sweet foods – yes/no
Chest pain or breath loss on exertion – yes/no
Headaches or dizziness – yes/no
Any heart condition – yes/no
Diabetes – yes/no
High blood pressure 140/90 or above – yes/no
Stomach or Duodenal Ulcer – yes/no
Constant muscular pain – yes/no
Eating disorders – yes/no

Car or other accidents resulting in whiplash or other injuries – yes/no

Would you consider that your work, home life or relationships are stressful – yes/no

Please provide a break-down of an “average” day’s food and liquid intake.
Please include all foods, liquids consumed, food supplements taken and, if possible, rough timings of meals

Are there any foods you won’t or can’t eat?

Are you following any particular restrictive diet?

Do you suffer from any food intolerances or allergies?

Please give a break-down of your exercise/activity history and the nature of any current exercise program you are following:

All information provided will be treated as strictly private & confidential and will not be disclosed to any third party without your express permission
I confirm that to the very best of my knowledge all of the information provided on this questionnaire is correct and complete

Signature

Name

Date