JENNY BLONDEL
naturopathy : bioresonance

New Patient Health Evaluation Questionnaire – Gut supplement

Today's Date	Name	Date of birth

Circle (or mark with an 'X' if completing the form online) the extent to which you experience the following symptoms**.**

Scale: 1 means you never experience it and 5 means it is troublesome to you most of the time.

Upper Gastrointestinal system

1	2	3	4	5	Belching or gas within 1 hr of eating	1	2	3	4	5	Sweat often has a strong odour
1	2	3	4	5	Heartburn or acid reflux	1	2	3	4	5	Black or tarry coloured stools
			Y	N	Vegan diet (circle YES or NO)	1	2	3	4	5	Undigested food in stools
1	2	3	4	5	Stomach bloating within one hour after eating	1	2	3	4	5	Feel like skipping breakfast
1	2	3	4	5	Bad breath	1	2	3	4	5	Feel better if you don't eat
1	2	3	4	5	Stomach pains or cramps	1	2	3	4	5	Sleepy after meals
1	2	3	4	5	Diarrohea (chronic)	1	2	3	4	5	Diarrhoea shortly after meals
1	2	3	4	5	Fingernails chip peel or break easily	1	2	3	4	5	Stomach upset by taking vitamins
1	2	3	4	5	Anaemia that is unresponsive to iron supplements	1	2	3	4	5	Sense of fullness after meals
1	2	3	4	5	Loss of taste for meat	1	2	3	4	5	

Small Intestine

1	2	3	4	5	Food Allergies	1	2	3	4	5	Wheat or grain sensitivity
1	2	3	4	5	Abdominal bloating 1 to 2 hours after eating	1	2	3	4	5	Dairy sensitivity
1	2	3	4	5	Pulse speeds after eating	1	2	3	4	5	Asthma, sinus infections, stuffy nose
1	2	3	4	5	Airborne allergies	1	2	3	4	5	Use of antibiotics
1	2	3	4	5	Experience hives	1	2	3	4	5	Use over-the-counter pain medication
1	2	3	4	5	Sinus congestion “stuffy head”	1	2	3	4	5	Feel spacey or unreal
1	2	3	4	5	Crave bread or noodles	1	2	3	4	5	Specific foods make you tired or bloated
1	2	3	4	5	Alternating constipation and diarrhoea				Y	N	Are there any foods you could not give up (circle YES or NO)
									Y	N	Have a history of or currently have Crohn’s disease

Large Intestine/Colon

1	2	3	4	5	Anus itches	1	2	3	4	5	Irritable bowel or mucus colitis
1	2	3	4	5	Coating on the tongue	1	2	3	4	5	Blood in stool
1	2	3	4	5	Feel worse in mouldy or musty places	1	2	3	4	5	Mucus in stool
1	2	3	4	5	Fungus or yeast infections	1	2	3	4	5	Excessive foul-smelling lower bowel gas
1	2	3	4	5	Ring worm, “jock itch”, “athletes’ foot”, nail fungus	1	2	3	4	5	Bad breath or strong body odours
1	2	3	4	5	Symptoms above increase with sugar/starch/alcohol	1	2	3	4	5	Cramping/spasms in lower abdominal region
1	2	3	4	5	Stools hard or difficult to pass	1	2	3	4	5	Haemorrhoids

1	2	3	4	5	Less than one bowel movement per day	1	2	3	4	5	Raw fruits/vegetables/stress aggravate bowel pain
1	2	3	4	5	Lower abdominal pain, relief by passing stool or gas	1	2	3	4	5	More than three bowel movements daily
1	2	3	4	5	Diarrhoea (Loose watery stool)	1	2	3	4	5	Hard dry or pellet stool
1	2	3	4	5	Extremely narrow/ribbon like stool	1	2	3	4	5	Alternating Diarrhoea/constipation
1	2	3	4	5	Feel bowels do not completely empty	1	2	3	4	5	History of parasites
1	2	3	4	5	Stools are not well formed (loose)	1	2	3	4	5	

Liver and Gallbladder

1	2	3	4	5	Stomach upset by greasy foods	1	2	3	4	5	Sensitive to chemicals (perfume, cleaning agents)
1	2	3	4	5	Nausea	1	2	3	4	5	Sensitive to tobacco smoke
1	2	3	4	5	Light or clay coloured stools	1	2	3	4	5	Exposure to diesel fumes
1	2	3	4	5	Headache over eyes	1	2	3	4	5	Pain under right side of rib cage
1	2	3	4	5	Consume artificial sweeteners (e.g. aspartame)	1	2	3	4	5	Feel sick if drink wine
1	2	3	4	5	Sensitive to artificial sweeteners (e.g. aspartame)	1	2	3	4	5	Easily intoxicated if drink wine
1	2	3	4	5	Chronic fatigue or fibromyalgia	1	2	3	4	5	Easily hung over if drink wine
1	2	3	4	5	Stool colour alternates from clay colour to brown	1	2	3	4	5	Yellowish colour of skin or eyes (if yes, please highlight this box)
1	2	3	4	5	Dry, flaky skin & hair	1	2	3	4	5	History of morning sickness (if yes, highlight box)
			Y	N	Gallbladder removed – circle YES or NO	1	2	3	4	5	Bitter taste in mouth especially after meals