BODY GENESIS

INSTITUTE

WEIGHT LOSS AND GUT HEALTH SOLUTIONS

Health and Wellbeing Questionnaire

Thank you for taking the time to complete the following questionnaire. This questionnaire will help to establish where your health and wellbeing is currently situated, as well as potential areas of focus for our face to face consulting sessions. The questionnaire is comprehensive, but not exhaustive.

Your answers to this health appraisal questionnaire will assist us in gaining information about your current symptoms and health concerns.
The questions can be answered as Yes or No or with some explanation where required.

We would appreciate it if you can answer all questions, as this will ensure the most accurate interpretation of your results. You may however leave a question blank if you are unsure of the answer.

> When treating disease it is MORE important to know what sort of person has a disease, than to know what sort of disease a person has.
>
> *HIPPOCRATES*
> Father of Modern Medicine

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NAME: _____ DATE: _____

GENERAL HEALTH QUESTIONS

1. What are your top 3 health issues that prompted you to make an appointment with our practice?

_____

_____

_____

2. How do you rate your general health?

☐ Very Fit ☐ Good ☐ Not very healthy

3. Are there any medical conditions for which you take regular medications?

_____ _____ _____

4. Have you had any previous surgery (specifically on the abdomen)?

_____

5. Do you Smoke? ☐ Yes ☐ No

6. Do you Drink? ☐ Socialy ☐ No ☐ Heavy Drinker

7. Do you get a healthy amount and quality of Sleep?

☐ Yes ☐ No

8. Do you engage in regular exercise (at least 3-4 times a week)?

☐ Yes ☐ No

9. How would you rate your diet? Are most of the meals:

◯ Healthy

◯ Moderately Healthy

◯ Mostly fast/junk food

10. What Dietary type are you?

- ◯ Regular meat eater
- ◯ Vegetarian (no chicken or fish)
- ◯ Vegan

11. When do you generally have dinner?

- ☐ 5-7 pm
- ☐ 7-9 pm
- ☐ After 9 pm

12. Do you have an allergy, problems with frequent colds?

- ☐ Yes
- ☐ No

13. Do you experience difficulty focusing - Brain fog?

- ☐ Yes
- ☐ No

14. How do you handle emotional challenges and stress?

_____

15. Do you experience poor self image or self esteem leading to depression or anxiety?

- ☐ Yes
- ☐ No

16. Do you take time for self care and relaxation? If yes, how much per week?

- ☐ Yes _____ /week
- ☐ No

17. Do you maintain a healthy weight? If not what, in your view is the main reason for this?

_____

18. Do you have any health goals that you want to achieve in the next 12 months?
Please List:

1. _____

2. _____

3. _____

GASTROINTESTINAL QUESTIONNAIRE

Do you experience any of the following symptoms

1. Indigestion ◯ No ◯ Mild ◯ Severe
2. Excess belching, burping ◯ No ◯ Mild ◯ Severe
3. Bloating or fullness commencing, during, or shortly after a meal ◯ No ◯ Mild ◯ Severe
4. Sensation of food sitting in stomach for a prolonged period after a meal ◯ No ◯ Mild ◯ Severe
5. Bad breath ◯ Yes ◯ No
6. History of anaemia or blood loss ◯ Yes ◯ No
7. indigestion or heartburn with spicy or fatty food, citrus, alcohol, or caffeine ◯ Yes ◯ No
8. Heartburn aggravated by lying down or bending forward, to ◯ Yes ◯ No
   waking up from a sleep at night with a choking sensation? ◯ Yes ◯ No
9. Difficulty or pain when swallowing
10. Vomiting blood or vomitus that has an appearance of coffee grounds ◯ Yes ◯ No
11. Abdominal pain, cramping and/or spasms ◯ Yes ◯ No
12. Diarrhoea (loose, watery or frequent bowel movements) ◯ Yes ◯ No
13. Constipation (requiring straining, or a hard, dry or small stool) ◯ Yes ◯ No
14. Alternating diarrhoea and constipation ◯ Yes ◯ No
15. Sensation of incomplete emptying of bowel ◯ Yes ◯ No
16. Red blood with bowel movement or black tarry stools ◯ Yes ◯ No
17. Rectal pain or cramps ◯ Yes ◯ No
18. Anal itching ◯ Yes ◯ No
19. Fatty foods cause indigestion or nausea ◯ Yes ◯ No
20. Yellowish discolouration of skin or eyes ◯ Yes ◯ No
21. Skin rashes, acne, dermatitis, or eczema ◯ Yes ◯ No
22. Difficulty gaining or losing weight ◯ Yes ◯ No
23. Do you have a confirmed diagnosis of sleep apnoea? ◯ Yes ◯ No
24. Do you snore loudly? ◯ Yes ◯ No
25. Do you often feel tired/fatigued during the daytime? ◯ Yes ◯ No
26. Has anyone observed you stop breathing during your sleep? ◯ Yes ◯ No
27. Do you have or are you being treated for high blood sugar/diabetes/heart attack/angina? ◯ Yes ◯ No
28. Do you have a history of blood clot/deep vein thrombosis/pulmonary embolism? ◯ Yes ◯ No
29. Are you able to climb more than 1 flight of stairs without stopping? ◯ Yes ◯ No