

Please ensure you use the correct postage i.e. a large stamp. Otherwise there may be a long delay.

###

### Please complete for all minors up to the age of 16 years

|  |  |
| --- | --- |
| **Name of parent / guardian:** |  |
| **Name of child / minor:** |  |
| **Address & Postcode:** |  |
| **Telephone:** |  |
| **Date of Birth (and Age):** |   |
| Current weight: |  (lbs / kg / stone) |
| Current height: |  (cm / metres / feet) |
| Reason(s) for completing the questionnaire today: |  |
| Health conditions / symptoms you are seeking support for your child: |   | How long has she/he had this |
| 1. |  |
| 2. |  |
| 3. |  |
| Name of GP: |  |

**Please forward my reply:**

 To my email below (Please print clearly)

Email: ………………………………………………………………………………………………………

**By signing below you are confirming that you have read and understood the Health Questionnaire Terms of Reference attached to this questionnaire (see page 9).**

**Signature of parent/guardian**………………….……………….……….……………………………

**Date:** ……………….……………….……….………………………….……………….……….…………

We will respond to your health questionnaire as soon as possible by post or email; telephone responses are not available. Please note health questionnaire support is not intended to replace a medical consultation or practitioner consultation. If you have health concerns it is important to obtain a medical diagnosis for your symptoms.

**Please email your completed health questionnaire to helen@cytoplan.co.uk**

**If returning by post to us, please mark on the envelope: FAO Helen Drake.** Please note that questionnaires returned **by post may have to wait up to 2 weeks to receive a reply**.

**Recent Consultations:**  Please provide approximate dates and details of any consultations:

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Date** | **Reason for Visit** | **Diagnosis / Treatments received** |
|  G.P.  |  |  |  |
|  Medical Consultant |  |  |  |
|  Practitioner/ therapist. Therapy ………………………….. |  |  |  |

**Please tick the box next to any of the following that apply to your child:**

|  |
| --- |
| **Does your child get any severe and/or persistent pain in any of the following:**   |
|  Head Abdomen Chest | EyeTempleOn passing urine |
| Other please write in: |

|  |
| --- |
| **Does your child ever get blood in any of the following:**  |
|  Vomit Stools | UrineSputum |
| **Has your child recently had any changes in:**  |
|  Level of thirst Skin Urination Breathing  |  Weight Vision  Body/face shape  Personality/ behaviour  |  Appetite Bowel movements Swallowing |

**Your Child’s Health History**

Has your child now or in the past experienced any of the following? Tick if the answer is **YES**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition** | **Now** | **Past** | **Condition** | **Now** | **Past** |
| Allergies |  |  | Anxiety |  |  |
| Arthritis |  |  | Asthma |  |  |
| Bowel problems |  |  | Cancer |  |  |
| Diabetes |  |  | Depression |  |  |
| Ear/eye/nose/throat  |  |  | Drug/alcohol dependence |  |  |
| Epilepsy |  |  | Eczema/skin conditions |  |  |
| High blood pressure |  |  | Heart conditions |  |  |
| Osteoporosis |  |  | Menstrual  |  |  |
| Stomach ulcers |  |  | Sleep problems |  |  |
| Urinary tract conditions |  |  | Thyroid problems |  |  |

**Other diagnosed conditions:**

………………………………………………… ……………………………………………….

………………………………………………… ……………………………………………….

**Digestive Function**

|  |  |
| --- | --- |
| **Does your child experience the following?** | **Please provide details of any which occur regularly** |
| Abdominal bloating  |  |
| Acid reflux  |  |
| Bloating after meals |  |
| Burning pains in stomach  |  |
| Burning pain in throat  |  |
| Constipation  |  |
| Diarrhoea  |  |
| Diverticula |  |
| Flatulence belching  |  |
| Flatulence rectal  |  |
| Frequent urging to stool  |  |
| Hemorrhoids |  |
| Irritable Bowel syndrome |  |

**Female only:** please indicate if monthly menstruation is present: Yes No

Is your child prescribed hormonal contraception? Please provide drug names

……………………………………………………………………………………………………………

Additional menstrual information: ……………………………………………………………………………..

**Surgical procedures:** Please provide details of any surgery and approximate dates.

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………

**Prescribed Medicines:** Please list all medications your child is currently taking and include dose. This information is important to enable us to suggest safe and appropriate nutritional supplements for your child. **Please continue on a separate sheet if needed.**

|  |  |  |
| --- | --- | --- |
| Name of medication | What is it for? | Daily Dose |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Non-prescription medications used:** Please list any medications, laxatives, herbal products and/or homeopathic remedies that your child takes on a regular or frequent basis.

………………………… ………………………… ………………………… …………………………

# Supplements: Please list all supplements that your child is taking currently, dose and brand names:

………………………… ………………………… ………………………… …………………………

………………………… ………………………… ………………………… …………………………

Please list any **recently discontinued** medications or supplements?

………………………… ………………………… ………………………… …………………………

**Family Medical History.** Pleaseprovidedetails belowof family health conditions **.** e.g. Angina, Alzheimer’s, Arthritis, Asthma, Blood pressure, Cancer, Dementia, Diabetes, Heart disease, Lung disease, Osteoporosis, Parkinson’s disease, Stroke.

**Parents**………………………………………………………………………………………………………

…………………………………………………………………………………………………………………

**Grandparents**………………………………………………………………………………………………

…………………………………………………………………………………………………………………

**Brothers/Sisters**…………………………………………………………………………………………..

…………………………………………………………………………………………………………………

**Nutrition and Diet** please tick those boxes that relate to your child’s present diet:

Mixed food diet (animal and vegetable sources)

Vegetarian

Lacto vegetarian

Lacto ovo vegetarian

Salt restriction

Fat restriction

Starch/carbohydrate restriction

Other dietary plans, please detail …………………………………………………………………….

**Food exclusions**: please list any foods you **exclude** from your child’s diet**.** e.g. dairy, eggs, soy, wheat, gluten

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………

Has your child taken any food allergy/intolerance tests? Please state type of test undertaken and results

………………………………………………………………………………………………………………

**Food Frequency:**

**Fruit:**How many portions of fruit does your child eat …….. **Each day** Name below those fruits that you eat regularly:

………………………… ………………………… ………………………… …………………………

**Vegetables**: How many portions of vegetables does your child eat ……. **Each day**

Name below those vegetables that they eat regularly:

………………………… ………………………… ………………………… …………………………

………………………… ………………………… ………………………… …………………………

**How many slices of bread does your child eat per week of the following ?**

White ..…….. Wholemeal ..…….. Granary ..…….. Rye ..…….. Wheat free ..…….. Gluten free ..……..

**How many portions /week does your child eat of the following?**

Please insert approximate number.

Pulses, beans, lentils etc..……. Beef ..……. Lamb ..……. Pork ..……. Chicken ..……. Turkey ..…….

Eggs..……. Milk ..……. Yogurt ..……. Cheese ..……. White fish ..……. Tuna ..……. Salmon ..…….

Trout ..……. Herring ..……. Sardines ..……. Mackerel ..…….

**What grains does your child eat on a weekly basis?** Tick boxes below

 Wheat Corn White rice White Pasta Quinoa Millet

 Oats Rye Brown rice Wholemeal pasta Couscous Bulghar wheat

# Eating Habits please tick all of the following which apply.

# skips breakfast

grazes (small frequent meals)

regularly misses meals

eats constantly whether or not hungry

generally eats on the run

adds salt to food

adds sugar to drinks. Number of teaspoons per drink…………

**Fluids -** Cups per **day** of: Coffee ... Tea ... Green Tea ... Herb Teas ... Decaff tea or coffee ...

Glasses per **day** of: Fizzy Drinks … Cordial ... Fruit Juice ... Diet drinks ... Energy Drinks ...

Water glasses (250ml) per day ……. **OR** litres per day …….

**Exercise:** How many days per week does your child exercise?

# 1-2 days 2-3 days 4-5 days 6-7 days

Duration per session: less than 30 minutes30-45 mins45 mins or more

**Please describe the types of exercise undertaken on a regular basis:**

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………

………………………………………………………………………………………………………………

|  |
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| **How motivated are you / your child to change the way you eat and to experiment with new foods?** I am willing to try anything that might improve my child’s condition I feel I can cope with a moderate amount of change I feel very anxious about changing my child’s dietary/lifestyle habits Please rate your motivation on a scale of 0 to 10 (0=low; 10=high):Please rate your child’s motivation on a scale of 0 to 10:  |

**Food Diary**

Please write down all the foods and drinks your child consumes over a **3** day period, include **1** weekend day.

Please complete as **accurately** and **honestly** as possible.

**The following represents my child’s diet for the:** last month 6 months plus 1 year plus

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Breakfast** | **Lunch** | **Dinner** | **Snacks** | **Fluids** |
| **Day 1** | **Day 1** | **Day 1** | **Day 1** | **Day 1** |
|  |  |  |  |  |
| **Day 2** | **Day 2** | **Day 2** | **Day 2** | **Day 2** |
|  |  |  |  |  |
| **Day 3** | **Day 3** | **Day 3** | **Day 3** | **Day 3** |
|  |  |  |  |  |

Example

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Breakfast** | **Lunch** | **Dinner** | **Snacks** | **Fluids** |
| **Day 1** | **Day 1** | **Day 1** | **Day 1** | **Day 1** |
| Porridge with honey | Ham sandwichCrisps | Roast ChickenCarrotsPeasMashed potatoApple pie & custard | CrispsChocolate barApple | Tea 4 cupsCoffee 1 cupWater 1 glass |

Any additional information you wish to provide may be given below:

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Please ensure you use the correct postage i.e. a large stamp. Otherwise there may be a long delay in us receiving the questionnaire and we will be asked to pay the excess postage. Thank you.

**MYMOP - MEASURE YOURSELF MEDICAL OUTCOME PROFILE**

 **The questionnaire below is used to measure changes in health outcomes following health recommendations. It is recommended to take part in a follow up questionnaire after 2-3 months, this enables us to identify any improvements or additional requirements to make appropriate recommendations as well as tracking effectiveness of recommendations. This data may be used for case studies, which will be completely anonymous and will not be used without permission of the client.**

This form was developed from the MYMOP2 form from Bristol University

<http://www.bris.ac.uk/media-library/sites/primaryhealthcare/migrated/documents/initialform.pdf>

Initials................................ Date…………………………………………….

Choose one or two symptoms (physical or mental) which bothers them the most. Write them on the lines.

Now consider how bad each symptom is, over the last week, and score it by circling or highlighting your chosen number.

**SYMPTOM 1:** ...........................................................................................................................................

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

As good as it could be As bad as it could be

**SYMPTOM 2:** ...........................................................................................................................................

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

As good as it could be As bad as it could be

Now choose one activity (physical, social or mental) that is important to them, and that their problem makes difficult or prevents them doing.

Score how bad it has been in the last week.

**ACTIVITY:** .................................................................................................................................................

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

As good as it could be As bad as it could be

Lastly how would you rate their general feeling of wellbeing during the last week?

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 |

As good as it could be As bad as it could be

How long have they had Symptom 1, either all the time or on and off? Please circle:

0 - 4 weeks 4 - 12 weeks 3 months - 1 year 1 - 5 years over 5 years

**HEALTH QUESTIONNAIRE SERVICE – TERMS OF ENGAGEMENT**

**Health Questionnaire Service:** This free service, which is available from our in-house Registered Nutritional Therapist, is offered to our customers as we recognise the importance of diet, lifestyle and choosing appropriate supplements as important to support health improvement. Offering this no obligation service is also in line with our charitable objectives; we are wholly owned by a charitable foundation that supports environmental and health improvement projects globally.

If you complete and return the attached questionnaire, our Registered Nutritional Therapist will send you some written diet and supplement recommendations to support your child’s health goals.

**However, please be aware that as a postal questionnaire we are limited in the suggestions and support we can provide**.

**The Nutritional Therapist requests that the client notes the following:**

* The degree of benefit obtainable from the recommendations may vary between clients with similar health problems and following a similar programme.
* Nutritional advice will be tailored to support health conditions and/or health concerns identified on the health questionnaire.
* We are not permitted to diagnose, or claim to treat, medical conditions.
* Nutritional advice is not a substitute for professional medical advice and/or treatment.

**The parent / guardian understands and agrees to the following:**

* You are responsible for contacting your child’s GP about any health concerns.
* If your child is receiving treatment from his/her GP or any other medical provider you should tell them about any nutritional strategy provided by a Nutritional Therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
* It is important that you tell your Nutritional Therapist about any medical diagnosis, medication, herbal medicine or food supplements your child is taking as this may affect the nutritional programme.
* If you are unclear about the agreed programme / food supplement doses / time period, you should contact the Nutritional Therapist promptly for clarification.
* **You must contact the Nutritional Therapist should you wish to continue any specified supplement programme for longer than 3 months**, to avoid any potential adverse reactions. In any case we recommend a regular review of supplements to ensure they remain appropriate for your child’s needs.
* You are advised to report any concerns about your child’s programme promptly to your Nutritional Therapist for discussion / action.
* Please note we do recommend that all supplements are taken at different times of the day to any prescribed medications.

***We would always recommend you discuss any dietary or supplemental concerns or changes you wish to make with your child’s G.P. Medication should never be discontinued or dosage amended without the G.P.’s prior knowledge and agreement.***

I understand the above and agree that the health questionnaire service provided by Cytoplan Ltd will be based on the content of this document. I declare that all the information we share on this health questionnaire is confidential and, to the best of our knowledge, true and correct.

**Name of parent/guardian: ……………………………….. Parent / guardian Signature:……………………………**

**Date:………………………………. Relationship to child: ………………………………………………………………………**