Questionnaire 1st consultation

Integrative and Holistic Medicine

Name:

Date: ____ / _____ / 202__

The data collected is confidential and only used for clinical purposes during the consultation.

Over the last 3 months**, ON AVERAGE**, how often/how much have you consumed the following foods? (If you have recently changed your eating habits, please answer according to the new habits implemented)

Category	Food	Frequency
Bread	White, wholemeal,	how many per day ______ or week _______ or per month _________
	Sourdough	how many per day ______ or week _______ or per month _________
Flours	Cookies	how many times a day ______ or week _______ or per month _________
	Cakes	how many times a day ______ or week _______ or per month _________
Dairy products and substitutes	Cow's milk *(with or without lactose)*	how many times a day ______ or week _______ or per month _________
	Cow's yogurt (with or without lactose)	how many times a day ______ or week _______ or per month _________
	Plant-based yogurt (soy, coconut…)	how many times a day ______ or week _______ or per month _________
	Butter (cow's butter)	how many times a day ______ or week _______ or per month _________
	Margarine or vegetable butter (Becel, flora, soy)	how many times a day ______ or week _______ or per month _________
	Cheese	how many times a day ______ or week _______ or per month _________
Savory foods	Ham / sausages	how many times a day ______ or week _______ or per month _________
	Croquettes, puff pastries	how many times a day ______ or week _______ or per month _________
Fast Food	Pizza / French fries burger, etc.	how many times a day ______ or week _______ or per month _________
	Ketchup / Mayonnaise	how many times a day ______ or week _______ or per month _________
Candy	Chocolate / Nutella	how many times a day ______ or week _______ or per month _________
	White/brown sugar	how many times a day ______ or week _______ or per month _________
	Jam/Honey/Marmalade	how many times a day ______ or week _______ or per month _________
	Peanut butter	how many times a day ______ or week _______ or per month _________
Drinks	Coffee	how many per day ______ or week _______ or per month _________
	Decaffeinated	how many per day ______ or week _______ or per month _________
	Wine (glasses ~ 20cL)	how many per day ______ or week _______ or per month _________
	Beer (33cL bottle)	how many per day ______ or week _______ or per month _________
	White Drinks (glasses)	how many per day ______ or week _______ or per month _________
	Soft drinks or fruit juices	how many per day ______ or week _______ or per month _________

Food	Frequency
Tropical fruit (banana, mango…)	how many per day ______ or week _______ or per month _________
Local fruit (apple, pear, orange..)	how many per day ______ or week _______ or per month _________
Nuts (walnuts, almonds, etc)	how many per day ______ or week _______ or per month _________
Eggs (including in desserts)	how many per day ______ or week _______ or per month _________

- **What % of the food you eat is organic?** 0-25% ☐ 26-50% ☐ 51-75% ☐ +75% ☐
- **Do you have any food allergies or intolerances?** Which: ____

Meals

FAST- Do you take anything? What?

BREAKFAST- What do you usually eat?(fill in the space below) At what time ___:___H

MID MORNING- What do you usually eat? (fill in the space below) At what time ___:___H

LUNCH - What time ___:___H

- What % of lunches do you eat at home or are home-made (0-100%): ________%
- What % of Lunches have Soup (0-100%): ______ %
- During the week (7 lunches) how many times do you eat meat for lunch? ______
- During the week (7 lunches) how many times do you eat fish for lunch? ______
- During the week (7 lunches) how many times do you eat eggs for lunch? ______
- During the week (7 lunches) how many times do you eat vegetarian lunch? ______
- What cereals do you usually eat at mealtime? (mark with **+** (a lot); **–** (a little) or **0** (never))
  Bread ____ | Rice ____ | White Potato ___ | Pasta ___ | Brown Rice ___ | Sweet Potato _____
  Couscous ____ Quinoa ____ | Millet ____ | Buckwheat ____ | Others? Which: _____________
- What % of the plate contains vegetables? Little or none☐ 1/4 of the plate☐ 1/3☐ 50% or more☐
- The Vegetables are: More salad ☐ | More cooked ☐ | 50/50☐
- Do you usually eat dessert or fruit at the end of a meal? ______ What: ________________________

MID AFTERNOON -What do you usually eat? (fill in the space below) At what time ___:___H

DINNER - What time ___:___H

- What % of meals have Soup for dinner (0-100%): ________
- The amount of food at dinner is: More than lunch ☐ Same as lunch☐ Less than lunch ☐
- Do you usually eat dessert or fruit at the end of a meal? ______ What: ________________________
- Do you have any supper or get up during the night to eat? What? _________________________________

- **What type of water do you drink?** Bottled☐ Faucet☐ Filtered☐ Mine☐
- **How much water and tea do you drink per day:** < 0.5L ☐ 0.5-1L ☐ 1-1.5L☐ 1.5-2L☐ >2L☐
- **Do you drink liquids with meals? What?** Water ☐ Wine☐ Soft drinks☐ Tea☐ Nothing☐
- **Do you snack a lot during the day?**_________ How is your appetite? Little☐ Normal☐ High☐
- **How fast do you eat your meals?** Quickly and chew little ☐ Normal ☐ Slowly☐
- **Do you have cravings for a certain type of food/flavor?**____

Lifestyle Habits and Body Systems

you can tick multiple boxes if applicable

Weight______Kg **What weight do you want?** _______Kg **Height** __.____m

Do you exercise (including walking)?______________

What ________________________________ How many times/time per week? __________________

What ________________________________ How many times/time per week? __________________

Do you currently smoke? _____ **How many cigarettes per day**____ or per month ____

Have you ever been a smoker? ______ How many years in total? _____ How long since you quit? _______

How do you rate your daily energy level from 0 to 10? _______

Have you taken any antibiotics in the last 3 years? For what purpose?_______________________________

Did you take a lot of antibiotics as a child? For what purpose? _________________________________

Have Rhinitis☐ **or Sinusitis?**☐ **Do you have respiratory allergies? To what?** ______________________

How many doses of the COVID vaccine have you had? _______ **Did you have any side effects?** __________

How many devitalized teeth do you have ?☐ **with white mass?**☐ **with lead?**☐

Do you have a dental implant/prosthesis?________ **Do you have bruxism?** _____ **Retainer?** _____

Do you have tattoos?______ **Piercings?** _______ **Botox?** _____ **Cosmetic Procedures?** _____

Hair problems: Lots of falls☐ Brittle☐ Dandruff Dry☐ Oily☐ Seborrhea☐

The fingernails are: Normal☐ Fragile ☐ Any fungal infections on your nails? Feet☐ Hands☐

Skin Problems: Dry☐ Oily ☐ Acne☐ Eczema ☐ Rosacea☐ Other: __________

Sweats: A lot☐ Normal☐ Little☐ Does your sweat have a strong smell? ______

Do you have pets or regular contact with animals? Which ones: _______________________

Have you ever traveled to tropical country? Which: __________________________________

What time do you fall asleep? ____________ **What time do you get up in the morning?** ______________

Do you fall asleep easily?___________ **Light sleeper?**☐ **Deep sleeper?**☐ **Do you dream a lot?**☐

Is your sleep restorative☐ **wake up tired?**☐ **Do you snore?** _______ **Do you have sleep apnea?** ______

Do you have any of these digestive symptoms? Heartburn☐ Reflux☐ Swelling ☐ Burps a lot☐

Pain if you don't eat☐ Pain after eating☐ Nausea/Sickness☐ Sleepiness after lunch☐

The intestine works: How many times a day? ______ or How many times a week? ____

Stool consistency: Very hard☐ Pellets/balls☐ "Normal"☐ Pasty☐ Diarrhea☐

Do you have a lot of gas?_____ smelly?☐ or odorless?☐ History of hemorrhoids?: ______

♀ Woman

Do you have a menstrual period?_____ **Do you use:** Pill☐ IUD☐ None☐ Other: ___________

Nº of days in the complete cycle*(e.g. 26-28)* _______ **Nº days of menstruation***(ex: 4-5)* ___________

Flow: Abundant☐ Normal☐ Little☐ **Blood clots?** ________ **Menstrual pain?** ________

Are you in menopause? Since when? _______ **Any symptoms?:** _____________________

How many pregnancies?☐ Nº of children☐ **Libido:** Absent☐ Reduced☐ Normal☐

Do you have frequent candidiasis?☐ **Do you have recurrent urinary tract infections**☐

Man

Erection problems: No☐ Yes☐ **The urinary stream is:** Normal☐ Weak ☐

Do you wake up during the night to urinate?_____ **How many times?** ______

Libido: Absent☐ Low☐ Normal☐

Usual Pharmaceutical Medication			Supplementation / Vitamins		
Name	**Dose**	**Frequency**	**Name**	**Mark**	**Frequency**
(Example: Aspirin)	*(100mg)*	*(1x/day)*	*(Example: C-Complex)*	*(Sattvi)*	*(2x/day)*

Do you have pain in any part of your body? Where?	Have you had any surgery? In what year? *(example: Cesarean Section – 2020)*

In order of importance what are the problems that bother you the most and that you want to solve?

1 -		**4 -**	
2 -		**5 -**	
3 -		**6 -**	

Do you have Diabetes? ☐ **Hypertension?** ☐ **High cholesterol?** ☐ **History of Depression?** ☐

From 1 to 5 how often do you feel the following emotions/sensations?

(1 = almost never | 2 = rarely | 3 = sometimes | 4 = often | 5 = almost always)

Sadness ☐ Irritability ☐ Fear ☐ Happiness ☐ Peace ☐ Optimism ☐ Pessimism ☐

Anxiety ☐ Abandonment ☐ Mood swings ☐ Stress at work ☐ Stress at home ☐

I am interested in receiving information by email about

Additional clinical information for the consultation ☐

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Date:____/____/20___ Signature: ____________________________