questionnaire time line

Adriana Candeias © 2019 www.adrianacandeias.com mail@adrianacandeias.com

Please complete this form as thoroughly as possible. This information is of great value for our strategy design and it will be kept confidential.

1. List the reason(s) you would like to consult me
2. List any current medication including pharmaceutical drugs, hormonal treatments and the birth control pill, supplements, herbal and other remedies.
3. List any other current natural or conventional treatments you are using to treat any other conditions.
4. Which part or side of your body tends to be affected
5. Do you feel warmth, chills, pins & needles, urticaria, etc?
6. How is your sleep (regular, short, heavy, restful, agitates, length, …)?
7. What about dreams?
8. Nutrition
9. Describe your relationship to different diets, favourite foods, sensitivities and reactions and allergies.
10. List any reactions to vaccinations, antigens, or any environmental allergy.
11. BODY SCAN
List any present symptoms, sensations, and sensitivities in the following,
	1. Nose & mouth
	2. Throat & Chest
	3. Lungs & Breathing
	4. Heart, blood pressure, pulse
	5. Digestive
	6. Intestines, stools
	7. Rectum
	8. Kidneys & urination
	9. Reproductive and sexual organs
	10. Back
	11. Neck & shoulders
	12. Arms, wrists & hands
	13. Hips, legs, knees & feet
	14. Skin
	15. Nervous System
12. MEDICAL HISTORY AND SIGNIFICANT EVENTS

In order to assess your strengths and susceptibilities, I will need to have a chronological list of the most important moments of your life, either positive or difficult.
You do not have to describe details.

We will do that in the session, if needs be, nor you have to remember the exact date. The order of the events and your age at the time is useful.

This is an interesting exercise and you may like to ask friends and family for help.

Use the following checklist as a prompt

* pre-birth: any emotional or physical problems experienced by your mother during gestation
* birth: type of labour
* childhood illnesses: medications, accidents: medical interventions
* surgical procedures / major dental works: state if anaesthesia was necessary
* use of drugs: heavy and prolonged of both recreational and prescribed
* severe viral infections: meningitis, glandular fever, etc.
* shocks / traumas: anything which may have affected your mental, emotional or physical wellbeing
* changes: in house, jobs and career, country, relationships.

Example:

*1974 - Birth, vaginal, ventouse*

*1974 - breastfeed for 6 months*

*1974 - normal vaccination schedule*

*1975 - first asthma attack*

*1984 - parents divorced, changed school, difficult breathing came back, started using an inhaler.*

1. FAMILY MEDICAL HISTORY

List any diseases of blood relations, including cause and age of death where applicable, disabilities, history of addictions, and behavioural problems.

1. MATERNAL
	1. Mother
	2. Grandmother
	3. Grandfather
	4. Aunts
	5. Uncles
	6. Cousins
2. PATERNAL
	1. Mother
	2. Grandmother
	3. Grandfather
	4. Aunts
	5. Uncles
	6. Cousins
3. SIBLINGS
4. CHiLDREN