Hanna Evans
acupuncture + nutrition
BA Hons Lic Ac MBAaC NT DipCNM mBANT

(PRIVATE & CONFIDENTIAL)

Please fill in all relevant sections and either email back to me at evans.hanna@gmail.com or bring with you to your first appointment. If you don't have time to fill in before you come it can be sent or brought along at another. If you require more space than the boxes provide use additional paper.

Date: _____

CONTACT DETAILS

First Name:	Last Name:	Title:
Address:		Post Code:
Mobile:	Tel No (home):	
Email Address:		
Date of Birth:	Occupation:	
Age:	Height:	Weight:
GP: Address: Tel no:		
How did you hear about Hanna Evans?		

HEALTH INFORMATION

Please list your health concerns. Start with your main concern and state the duration of each. List in order of importance. Attach a separate sheet if needed.
1.
2.
3.
4.
Under what conditions do you notice your health concerns worsening? **Under what conditions do you notice your health concerns improving?**

07799 417924 evans.hanna@gmail.com www.hannaevans.co.uk

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MEDICAL HISTORY

Please detail any childhood illnesses or accidents:	
Were you delivered naturally or via caesarean:	As a child, did you eat a lot of sugary foods:
Were you breast fed:	As a child, did you suffer with ear infections:
Have you ever had an eating disorder:	As a child, did you suffer with bed wetting:
Did you have a lot of antibiotics as a child?	
Details of any surgery or operations. Include dates:	**Have you had any other illnesses in the past?**
Are you currently taking any medication? Name, daily dose, duration:	**Which drugs or medication have you taken in the past?** Include reason for taking, duration and dosage:
Have you had any medical tests? If yes, which ones, when and, if available, please provide or bring along a copy of the results.	**Are you currently taking any vitamin or herbal supplements**? Name, daily dose, duration:
Is your blood pressure high, low or normal?	
If known, what is your blood type:	

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FAMILY HISTORY

Do you have any children? Indicate age, sex, any illnesses:
Do you have any siblings? (Please give ages and sex):
Do your siblings have any illnesses? If so, please give details:
How old is your father? (If deceased, state age he passed away and cause of death): **What illness is/was your father prone to?**
How old is your mother? (If deceased, state age she passed away and cause of death): **What illness is/was your mother prone to?**
Please state, if known, the illnesses of your grandparents (If deceased, state age they passed away and cause of death). Please indicate (as shown) your mother's parents as; mother ^{MM} , father ^{MF} and your father's parents as; mother ^{FM} , father ^{FF} .

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GENERAL SYMPTOM & HEALTH ANALYSIS

Please answer the following questions.
(Y=Yes N=No O=Occasionally)

DIGESTION PROFILE

Rarely chew food thoroughly		Belching / bloating shortly after eating	
Eat whilst working or on the move		Offensive smelling wind	
Bad breath		Constipation	
Burning sensation in stomach		Diarrhoea	
Take indigestion tablets		IBS	
Stomach spasms/cramping during or after eating		Rectal pain, itching or cramping	
History of food poisoning		Piles/haemorrhoids	
History of gastric problems		Grind teeth in sleep	
Skip meals or eat erratically due to no appetite		Regularly eat sushi or rare cooked meat	
Small amounts of food fill you up immediately		White coated tongue	
Frequent nausea / pain after eating		Difficulty digesting fatty foods	
Feel hungry an hour or two after eating		Gallbladder problems	
Scaly ears		Headache over eyes	
Itchy feet or skin peels on feet		Bitter taste in mouth after meals	
Sea, car, plane or motion sickness		Dark orange urine	
History of morning sickness		Light or clay coloured stools	
State number of bowel movements a day		Blood in/on stool	
Bowel movement within 1 hour after eating		Mucus in/on stool	
Strain to pass a stool		Stools float	
Stools smell offensive		Unexplained itchy skin that's worse at night	
When massaging under your rib cage on your left side, there is tenderness		Are you tired after eating carbs?	

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IMMUNE PROFILE

More than 3 colds a year		Tonsillitis	
Find it hard to shift an infection		Flu symptoms last longer than 5 days	
Take antibiotics more than twice a year		Swellings in the neck, groin or armpit	
History of antibiotic use		Boils or styes	
Family history of allergies		Cold sores	
Ears ache, itch, feel congested or sore		Skin rashes	
Eyes water or tear		Acne	
Bed wetting as a child		Puffy eyes or dark circles under eyes	
Eczema		Excessive swelling from insects	
Asthma		Slow wound healing	
Hay fever		Glandular fever in the past	
Nose is continually congested		Bleeding gums	
Need to breath through mouth		Have a autoimmune condition	
Infections settle in your lungs		History of cancer in your family	
Wheezing		Cancer diagnosis	
Excessive mucus or phlegm		Biopsy	
Bruise easily		Body hair is thinning or disappearing	
Diagnosed with an autoimmune disease? If so, state which:			

STRESS PROFILE

Feel guilty when relaxing		Easily become angry	
Persistent need for achievement		Get impatient if people hold you up	
Unclear about your goals in life		Go to bed tired	
Competitive		Find it hard to 'switch off' at night	
Often do 2 or 3 tasks simultaneously		Wake up feeling refreshed	
Had a major personal loss / illness in the last 2 years		Recently split up from a long-term partner	
Experienced a major shock or trauma		Feel like your unable to cope	
Do you have frightening thoughts frequently?		Worrying gets you down	
Awakened out of your sleep by frightening dreams		Loss of interest in friends, work or hobbies	
What time do you wake up in the morning		What time do you go to sleep in the evening	

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BLOOD SUGAR PROFILE

Need more than 8 hours sleep		Frequently urinate day and/or night	
Difficult to wake in the morning		Excessive sweating	
Miss meals on a regular basis		Experience dizziness or irritability when missing meals	
Drink coffee or tea throughout the day		Poor concentration	
Energy dips – highs and lows		Feel forgetful	
Crave sweet foods or sweet drinks		Disturbed sleep	
Crave salty foods		Cravings for alcohol	
Get very thirsty		Athletes foot, fungal toenails	
Dry mouth		Easily fatigued	
Lightheadedness when standing up quickly		Need to eat frequently	

HORMONE PROFILE

Cold hands and feet for no reason		Goiter / swelling in the neck	
Feel the cold		Protruding eye balls	
Weight gain or weight that is difficult to shift		Weight loss / difficulty maintaining weight	
Excessively tired or sluggish		High appetite	
Depression / easy to cry		Low appetite	
Outer third of eyebrow thinning disappearing		Hyperactivity	
Hair loss or thinning hair		Nervousness	
Dry coarse hair		Anxiety	
Dry skin		Panic attacks	
Weak nails		Headaches / migraine	
Anaemia		Visual disturbances	
Insomnia / disturbed sleep		Mood changes	
Vivid dreams		Infertility	
Poor memory		Early menopause	
Spontaneous sweating		Voice is becoming deeper	

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QUESTIONS FOR WOMEN ONLY

Are you pregnant		Do you/have you used the birth control pill	
If so, how many weeks		If so, please state duration and type	
Trying to become pregnant		Use another method of contraception	
Length of time trying to conceive		If so, please state	
Had a miscarriage/s		Have irregular periods	
PCO / PCOS		Skin, hair, vagina and/or eyes feel dry	
Endometriosis		Have/had sexually transmitted disease – state	
Ovaries removed – state date		Recurrent cystitis	
Low libido		Fibroids	
Recurrent thrush		Fibrocystic breasts	
Increase of facial / body hair		Osteopenia / Osteoporosis	
Night sweats		Vaginal discharge	
Abnormal PAP test results?		Are you peri or postmenopausal?	
PMS If so, do you suffer with any of the following: (underline all that apply) Cramping, anxiety, irritability, mood swings, anger, frustration, increased appetite, sweet cravings, fatigue, headaches, depression, tearfulness, forgetfulness, insomnia, bloating, swelling of hands/feet, weight gain, breast tenderness.		If so, do you suffer with any of the following: (underline all that apply) Hot flushes, night sweats, aching joints, mood swings, poor memory, dry skin, vaginal dryness, dry eyes.	

QUESTIONS FOR MEN ONLY

Mood swings or depression		Post urination dribbling	
Loss of motivation and drive		Difficulty urinating	
Loss of libido		Urgent/painful urination	
Impotence		Male pattern baldness	
Prostate or testes problems		Skin problems	
Have/had sexually transmitted disease - state		Low sperm count	
Frequent urination		Poor sperm morphology (quality)	
Incomplete bladder emptying		Undescended testes	

NERVOUS SYSTEM

Tinnitus		Blurred vision or tunnel vision	
Sciatica		Intolerance to heat	
Light sensitivity		Burning feet	
Poor balance		Frequent headaches	
Fuzzy thinking		Poor sentence constructions	
Frequent pins and needles		Neuropathy	
Numbness in hands and/or feet		Depression	
Incontinence (bladder or bowel)		Fainting	

JOINTS & MUSCLES PROFILE

Swollen joints		Muscle cramps, twitches or spasms	
Aching muscles not due to exercise		Restless legs	
Diagnosed with fibromyalgia		Prone to sprains / strains	
Diagnosed with arthritis		Recover from exercise quickly	
Restricted movement of joints		Have a physical disability. State which:	

HEART & CIRCULATION PROFILE

Is there a history of heart disease in your family		High cholesterol	
Blood pressure over 140/90		Obese	
Resting pulse over 75		Oedema	
More than 14lbs (7kg) over your ideal weight		Varicose veins	
Do less than 2 hours exercise a week		Chest pain	
Sensation of heart beating too quickly/slowly/irregularly		Exhaustion with minor exertion	
Feel jittery		Heavy sweating (no exertion, no hot flashes)	
Heart palpitations		Shortness of breath	

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DIETARY PROFILE

Write down all the foods and drinks consumed over the next three days starting today. Please include as much information as possible, including quantities eaten, brand names and whether the food is fresh or packaged, refined or natural.

DAY 1	DAY 2	DAY 3
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner
Snacks	Snacks	Snacks
Drinks	Drinks	Drinks

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GENERAL CONSUMPTION

TIMES PER DAY	0	1	2	3	4	5	6	6+
Raw fruit								
Raw vegetable/salad								
Cruciferous vegetables (spinach, cabbage kale, rocket, broccoli etc)								
Cooked vegetables								
Slices of wholemeal bread/rolls								
Slices of white bread/rolls/bagels								
Pints of milk – state type								
Coffee – state type								
Tea – state type								
Pint of water – is it filtered, tap or bottled?								

TIMES PER WEEK	0	1	2	3	4	5	6	6+
Red meat								
Game – venison/rabbit/pheasant/partridge								
Chicken/turkey								
Oily fish – salmon/mackerel/anchovies/sardines/herring								
White fish – cod/halibut/plaice/swordfish etc								
Shellfish – prawns/scallops/mussels etc								
Soya products								
Quorn products								
Pulses/beans								
Live yogurt								
Cheese								
Eggs								
Fruit juice								
Dried fruit								
Fresh nuts								
Seeds								
White rice								
White pasta								
Wholemeal rice/quinoa/millet/buckwheat								
Wholemeal pasta – state type								
Fried food – crisps/chips/samosas/fry-up etc								
Flame grilled or barbequed food								
Ready meals/readymade sauces								
How many times a week do you eat fast food/takeaways								
Tinned food – state type								
Sweet snacks – cakes/biscuits/cereal bars/flapjacks etc								
Savoury snacks – crisps/salted nuts/Bombay mix/twiglets/tortilla etc								
Confectionery/sweets/chocolate – state which								
Puddings								
Glasses of alcohol – state which								
Fizzy drinks – state which								

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Do you add salt to your cooking?		Do you or have you suffered from binge eating/anorexia nervosa/bulimia	
Do you add salt to your food?			
Do you avoid foods containing preservatives / additives?		Are you currently vegan	
		Previously vegan	
Do you avoid foods that contain sugar?		Are you currently vegetarian	
How many teaspoons of sugar do you add to your food or drinks each day?		Previously vegetarian	
		Do you always cook from scratch	
Do you use artificial sweeteners? State which.		Do you ever buy ready meals	
Do you frequently eat under stressful conditions or on the move?		What percentage of your diet is organic	
Does your job involve you eating out a lot?		List any foods you dislike	
Do you enjoy cooking?			
How would you describe your appetite? Poor Average Good			

IF YOU HAVE PETS DO THEY

Sleep in/on your bed		Walk on food preparation surfaces	

Please attach any additional information you feel may be useful

I have stated all conditions that I am aware of and this information is true and accurate:

Signature:

Date: