Kaliyoga Detox Retreat Questionnaire

Private and Confidential

Personal information

Name:	Date:
Address:	Home phone: Mobile phone:
Date of Birth:	Age:
Email:	Occupation:

Medical History

Doctor’s name:	Current Medication:
Doctor’s address:	Past Medication - including antibiotics,steroids, antihistamines, antacids etc. and a rough estimate of when taken:
Vaccinations - with rough estimate of when administered:	
Previous Homeopathic Treatment: (When and for how long?)	
What Is Your Blood Pressure Reading? If you do not know, please tick below where appropriate:	Blood Type:
Nose Bleeds:	Blurred Vision:
Ringing in ears:	Dizzy spells:
Numbness or tingling in hands/feet:	Headaches, typically in the morning:

Past History of Illness and/or Surgery: - **To include asthma, eczema, allergies, ear, nose and throat infections, mucus problems, candida, addictions, emotional problems and anything else you feel might be relevant.** - **This does not have to be in great detail, as we will go over this in the consultation**	
Present Medical Problems: - **Are you or have you ever suffered with any of the conditions listed below?**	
Cancer of the rectum or bowel:	**Anal fissures:**
Severe haemorrhoids:	**Anal fistula:**
Recent abdominal cirrhosis:	**Recent Surgery:**
Long term steroid use:	
Diverticulitis (with flare ups in the last 6 months:	**Crohn's Disease:**
Gall stones:	**Severe anaemia:**
History of congestive heart failure:	**Diabetes:**
Ulcerative Colitis:	**Kidney disease or failure:**
Anorexia or other such eating disorders:	
Emaciation:	**Severe Liver Disease:**
TB:	**Candida Imbalance:**

Are you pregnant or trying to be?	If so, how many months?
*If you have said **yes** to any of the above, or if you have any other serious health conditions that you think we should know about, please use this space to write more details. (How long have you had the condition, when was it diagnosed, how often you have it, when you last had it, what treatments you have tried, how does it affect you?*	
How would you describe your general level of health?	**What would you most like to get from participating in the detox retreat?**

SCORE SHEET

Have you ever taken antibiotics for longer than 10 days, or more than once per year? (If so score 5)	Score:
Have you ever had a high sugar diet, now, in the past or as a child? (If so, score 5)	**Score:**
Have you ever lived through a high level of stress? (If so score 5)	**Score:**
Have you ever had a high alcohol intake, or taken drugs? (If so score 5)	**Score:**
Have you ever had any steroid treatment – pills, injections, creams, inhalers? (For women this includes the contraceptive pill or hormone therapy) (If so score 5)	**Score:**

Present Symptoms

Score 1 point if a symptom is occasional or mild.
Score 2 points if a symptom is frequent or moderately severe.
Score 3 points if a symptom is really severe or disabling.

Mark YES opposite the symptom that applies to you

Symptom	
Depression, anxiety, irritability, mood swings	
Poor memory, lack of concentration, feeling spacey or unreal	
Fatigue, lethargy, feeling drained	
Indigestion, heartburn, food intolerance, bloating, intestinal gas	
Constipation, diarrhoea, irritable bowel syndrome, stomach ache, mucus in stools	
In women: Premenstrual syndrome, period pains or irregularities, infertility, endometriosis, loss of sex drive	
In men: Prostate problems, infertility, impotence, loss of sex drive	
In women: Vaginal burning, itching, discharge	
In men: Irritation of groin or genitals	
Muscle aches or weakness, joint pain or stiffness	
Eczema, psoriasis, rashes, itching, acne	
Athlete's foot, ringworm, fungal toe	
Cravings for sweet foods, chocolate, alcohol, bread	
Sensitivity to perfume, chemical smells, petrol fumes, tobacco smoke	
Any symptoms made worse on damp days or in mouldy places	
Dizziness, loss of balance, un-coordination	

Insomnia, waking un-refreshed, drowsy during the day, need for excessive sleep	
Body odour, bad breath	
Sores in mouth, sore throat	
Nasal congestion, post-nasal drip, sinusitis	
Pain or tightness in chest, wheezing or shortness of breath	
Urinary frequency, urgency, burning	
Spots in front of eyes, burning or watery eyes	
Recurrent ear infections, ear ache, deafness	
Easy bruising, chilliness, cold hands and feet	
Headaches, migraines	
Numbness, burning, tingling	
Irritation, itching around anus	

TOTAL SCORE:

DIET

It would be very helpful to us if you could write a food diary for a week. (We need you to be very precise and honest please.) Below is a timetable to help you.

What food and drink do you have most days? (Be precise. White or brown bread etc & what time?)

Breakfast:
Snack/Drink:
Lunch:
Snack/Drink:
Dinner:
Snack/Drink:

Alcohol ***(glasses and what drink)*****:**
Water ***(tap/mineral; how many glasses?)*****:**

Tea/Coffee ***(How many cups of each. Decaf or normal. Sugar/milk etc)*****:**
Which Foods Do You Avoid?
Which Food Would You Find Hard To Give Up?
How Many Cigarettes Do You Smoke Per Day?
What Supplements, If Any Are You Taking?

FAMILY HISTORY OF ILLNESS: ***(To include asthma, eczema, allergies, heart problems, Alzheimers, Parkinson's, Diabetes, strokes, mental illness, cancer, bronchitis etc.)***
MOTHER:
FATHER:
MOTHER'S MOTHER:
MOTHER'S FATHER:
FATHER'S MOTHER:
FATHER'S FATHER:
SIBLINGS:
Any other family members with problems you think we should know about?
Anything Else Relevant That We May Have Missed?