Body · Soul · Mind

Comprehensive Health Questionnaire · Naturopathy & Epigenetics

You can complete this questionnaire by hand. Print it, write at your own pace, then scan it or take clear photos of every page in good light. Send it to info@anahealings.com. If a question does not apply or you prefer not to answer it, leave it blank.

Service	[ ] Naturopathy	[ ] Epigenetics

1 · About you

Full name	Date of birth
Today's date	Email
Phone / WhatsApp	Payment reference (optional)

General health [ ] Excellent/Excelente/Sehr gut [ ] Good/Buena/Gut [ ] Fair/Regular/Mittel [ ] Poor/Baja/Schlecht

Main reason for your visit

If you had a magic wand and could change three things about yourself or your life, what would they be?

What would you most like to optimise or understand?

2 · Health history

Past medical history - tick what applies

[ ]	Accidents / fractures / serious injury
[ ]	Allergies / asthma / eczema / hay fever
[ ]	Anaemia / bleeding problems
[ ]	Lung problems / pneumonia / emphysema
[ ]	Heart problems / high blood pressure
[ ]	Diabetes / thyroid / gland problems
[ ]	Gastrointestinal problems / ulcers / diarrhoea
[ ]	High cholesterol
[ ]	Cancer
[ ]	Liver / kidney problems
[ ]	Low back pain / headaches / other pain
[ ]	Skin disease
[ ]	Tuberculosis
[ ]	Sexually transmitted infections
[ ]	Depression / anxiety / other emotional concerns
[ ]	Neurological problems / seizures / MS / pinched nerve

Dates, details or other relevant history

Past surgery (approximate date and procedure)

Drug/food allergies or intolerances and reaction

Current medications, vitamins and supplements (name, dose, frequency and reason)

3 · Family, lifestyle & nutrition

Are you adopted?	Place of birth
Where did you grow up?	Current relationship status
Do you have children? How many?	Handedness
Education completed	Occupation
Do you feel stressed at work?	

Relevant family medical history (who and what condition)

Exercise: type, frequency and duration

Is there a spiritual practice or belief system meaningful to you?

Nutrition & habits

Fast food per week	
Dairy per week	
Meat/fish per week	
Grains/bread/rice/pasta per week	
Do you eat organic?	
Caffeine per day	
Sports drinks / juice / flavoured water per day	

Servings of fruit and vegetables per day	
Sweets per week	

Support & context

IMPORTANT: if you are in immediate danger, have thoughts of harming yourself, severe chest pain, serious difficulty breathing, major bleeding or another emergency, seek urgent medical care or call your local emergency service.

	Yes / Sí / Ja	No
Do you feel stress is a problem in your life?	[ ]	[ ]
Are you currently caring for an elderly or disabled family member?	[ ]	[ ]
Do you have major concerns about your children or your relationship with them?	[ ]	[ ]
Are you afraid of your own temper or someone else's in your family?	[ ]	[ ]
Do you sometimes feel out of control?	[ ]	[ ]
Do you sometimes feel you are no good or cannot do anything right?	[ ]	[ ]
Have you ever thought about suicide or harming yourself?	[ ]	[ ]
Do you live with someone who has serious health or emotional problems?	[ ]	[ ]
Is there a history of violence in your family?	[ ]	[ ]
Has anyone close to you physically hit or hurt you?	[ ]	[ ]
Do you feel unsafe in your current relationship?	[ ]	[ ]
Does a previous partner make you feel unsafe now?	[ ]	[ ]

How do you deal with conflict in your family?

Who provides you with emotional support?

Other health care providers you see regularly

Recent tests and dates: labs, MRI, CT, ECG, EEG, X-ray, ultrasound, colonoscopy…

4 · Physical symptoms (last 3 months)

Review of symptoms - tick Yes or No

	Yes / Sí / Ja	No
Difficulty falling or staying asleep	[ ]	[ ]
Nervousness / frequently ill	[ ]	[ ]
Headaches / dizziness / fainting / coordination / seizures	[ ]	[ ]
Weakness / numbness / paralysis	[ ]	[ ]
Skin changes / itching / bleeding / hair loss / changing moles	[ ]	[ ]
Double or blurred vision / eye pain / glaucoma	[ ]	[ ]
Runny nose / nose bleeding / polyps / sneezing	[ ]	[ ]
Mouth soreness / hearing difficulty / ringing / ear infection	[ ]	[ ]
Loss of appetite / difficulty swallowing / stomach pain / heartburn	[ ]	[ ]
Ulcers / vomiting / blood / gallbladder / hepatitis / jaundice	[ ]	[ ]
Constipation / diarrhoea / blood in stool / haemorrhoids / hernias	[ ]	[ ]
Asthma / bronchitis / COPD / emphysema / cough / shortness of breath	[ ]	[ ]
Chest pain / palpitations / irregular heartbeat / swollen ankles	[ ]	[ ]
Painful joints / cramps / arthritis / gout	[ ]	[ ]
Pain urinating / blood / infections / stones / loss of bladder control	[ ]	[ ]
Prostate problems	[ ]	[ ]
Breast pain or lumps / discharge	[ ]	[ ]
Spotting / hot flashes / dryness / abnormal vaginal discharge	[ ]	[ ]

Urination frequency (day / night) and observations

Menstrual / menopause / cycle / pregnancy history (if applicable)

Highest weight, weight last year, current weight and recent changes

5 · Emotional wellbeing & sleep

IMPORTANT: if you are in immediate danger, have thoughts of harming yourself, severe chest pain, serious difficulty breathing, major bleeding or another emergency, seek urgent medical care or call your local emergency service.

During the past week, rate 0-4

0 = none · 1 = mild · 2 = moderate · 3 = marked · 4 = severe

	0	1	2	3	4
Very low mood even with good news	[]	[]	[]	[]	[]
Low self-esteem or confidence	[]	[]	[]	[]	[]
Guilt or feeling like a burden	[]	[]	[]	[]	[]
Trouble falling asleep	[]	[]	[]	[]	[]
Waking 1-2 hours earlier	[]	[]	[]	[]	[]
Drowsy during the day	[]	[]	[]	[]	[]
Fatigue / low energy	[]	[]	[]	[]	[]
Decreased or increased appetite	[]	[]	[]	[]	[]
Increased weight	[]	[]	[]	[]	[]
Decreased or increased sexual interest	[]	[]	[]	[]	[]
Less interest / involvement / pleasure in usual activities	[]	[]	[]	[]	[]
Restlessness / unable to relax	[]	[]	[]	[]	[]
Racing thoughts	[]	[]	[]	[]	[]
Mood worse in the morning	[]	[]	[]	[]	[]
Thoughts of death or not caring whether I live	[]	[]	[]	[]	[]
Wanting to hurt or punish myself	[]	[]	[]	[]	[]
Physical anxiety symptoms	[]	[]	[]	[]	[]
Fear so strong I avoid situations	[]	[]	[]	[]	[]
Sudden feeling something terrible will happen	[]	[]	[]	[]	[]
Hearing voices or seeing things that are not there	[]	[]	[]	[]	[]
Strong suspiciousness	[]	[]	[]	[]	[]
Repetitive thoughts I cannot stop	[]	[]	[]	[]	[]
Compulsion to repeat actions	[]	[]	[]	[]	[]
Feeling outside my body / unreality	[]	[]	[]	[]	[]
Worried about my physical health	[]	[]	[]	[]	[]
Feeling rejected by others	[]	[]	[]	[]	[]

Usual sleepiness - rate 0-3

0 = would never doze · 1 = slight chance · 2 = moderate · 3 = high chance

	0	1	2	3
Sitting and reading	[]	[]	[]	[]
Watching TV	[]	[]	[]	[]
Sitting inactive in a public place	[]	[]	[]	[]
As a passenger in a car for an hour without a break	[]	[]	[]	[]
Lying down to rest in the afternoon	[]	[]	[]	[]
Sitting and talking to someone	[]	[]	[]	[]
Sitting quietly after lunch without alcohol	[]	[]	[]	[]
In a car while stopped for a few minutes in traffic	[]	[]	[]	[]

6 · Labs, reports & sending

Do you have laboratory results or reports you would like to provide? Describe what you are attaching or will email.

Final notes / additional information

I confirm the information is accurate to the best of my knowledge and consent to AnaHealings using it to prepare my support. I understand this questionnaire does not replace diagnosis or emergency medical care.

Signature	Today's date

Easy sending: 1) scan it or take clear photos; 2) check every page is readable; 3) email the files to info@anahealings.com and include your full name.