Individual Helthy Plan - questionnaire

I. General information

Name and Surname:	**Telephone:**	**Email:**	
Form of meeting*: ☐ on-line (skype) ☐ stationary		**Type of plan*:** ☐ Semi-annual Health Plan FAST PROGRAM ☐ Annual Health Plan SELF PROGRAM ☐ Annual Health Plan LONG TERM PROGRAM	
Date of birth:	**Sex and blood type:**	**Height:**	**Body weight:**
Medicines taken (including doses):			
Dietary supplements taken (including doses):			
Diseases (please state medical diagnosis, duration):			
Have you conducted a dietary intolerance test? If so, please specify the foods to which the test was conducted with severe hypersensitivity and the name of the test:			
Dietary habits of the last 5 years (e.g. high-protein diet, low-fat diet). Please give the full name of the diet and the duration of use:			
Please specify the purpose of the visit:			

* - check the appropriate box

II. Information about your current diet - please describe your usual diet below

Breakfast:
Snacks:
Lunch:
Snacks:
Diner/Supper:
Drinks (i.e. coffee, tea, juices, water, alcohol, etc.):

REMARKS:

III. Disease history/self-feeling/life style

Please describe the history of your first illness (e.g. migraine: when it started, medication taken, circumstances exacerbating the attacks, frequency and severity of attacks, etc.).
Please describe the history of your second illness.
Please describe the history of your third illness/sickness

Please describe the history of your fourth illness/sickness.
Please describe your daily energy level on a scale from 1 to 10 (morning, noon, afternoon, afternoon, evening).
How often do you give up your stool?
Do you play sports? If yes, how much and how much time do you have per week/month? (e.g. fast walking, 3 hours a week; skiing, 10 days a year).

IV. Informacje dodatkowe

Pregnancy and childhood (please tick or complete the information which concerns you):
1. Diseases of the mother during pregnancy:
2. Use of cigarettes/alcohol/medicines during pregnancy
Childbirth: natural forces/cesarian cutting/complications, if any
4. Breastfeeding to: _____/ artificial
5. Family atmosphere:
- warmth, love, support, security
- violence, alcohol, conflicts, conflicts, quarrels, sense of threat, loneliness, stressful atmosphere
- single parent
6. Siblings, if yes, how many, and which child are you, including miscarriages:
7 Relationship with siblings: good/bad
8. Other information about the family:
9. Childhood illnesses:
- intestinal colic, skin problems, asthma, allergies,
- overactivity, learning and concentration problems, convulsions
- infections: ear, third almond, removal of tonsils, third almond
- bronchitis, pneumonia, urinary tract inflammation, frequent colds, parasites
- diarrhoea, constipation
- bed-wetting
- use of antibiotics, other medicines

Have you travelled abroad? (please specify time and place)

Have you been exposed to pesticides, heavy metals, chemicals (amalgam seals, lots of tuna in your diet, mines near your home, work) or moulds? (please specify the specific substances, place and time of contact)

WOMAN:

1. First menstruation and last:
2. Nature of menstruation (generous/short/painful/regular/non-regular/long/long/short):

3. Period before menstruation (mood change/painful breasts/swelling/headaches excessive hair):

4. Pregnancy (possible problems with getting pregnant):
5. Miscarriages - if yes, how many:
6. contraception (how and for how long):

7. If there is a period of menopause, please describe the symptoms:

8. Do the following diagnoses apply to you?
- endometriosis, ovarian cysts/breast changes/uterine fibroids
- frequent urination/pain at urination/incontinence/faecal incontinence
9. whether there is a need for night-time toilet use
10. Last gynaecological examination:

A MAN:

1. Problems with urination/frequent urination/ pain in urination/ weak stream of urine
2. Is there a need to visit the toilet at night (how many times)?
3. Erection problems: yes/no

Stress description:

- large/medium/large/small
- difficult moments in life (e.g. divorce, loss of a loved one, change of job, other)
- relaxation techniques used e.g. meditation, yoga, breathing

A dream:

- Sleep time: Wake up time: Wake up time: Wake up at night: yes/no
- deep sleep/shallow
- snoring
- the use of sleeping pills

Tests done:

- Colonoscopy/Gastroscopy/USG/ Exercise test/Holter
- other:

Hospital stays other than treatments:

Treatments and surgeries:

V. Objawy

Please indicate the symptoms that affect you:

ORAL CAVITY

- □ cavities, if any, since when:
- □ amalgam amalgam - how many: removed - when: how much now:
- □ teeth treated with root canal treatment
- □ implants
- □ changes to mucous membranes (e.g. aphtha): oral cavity/language
- □ mycosis problems

LOOK AT THIS.

- □ reflection

- □ after eating, the feeling of oppression...
- □ flatulence
- □ a little appetite
- □ constipation and cramps
- □ allergies, food intolerances
- □ frequent indigestion
- □ abdominal pain/stomach pains in stress/meal pains
- □ dependence on hydrochloric acid suppressants (e.g. ppi, controloc)
- □ history of ulcers or erosions

CERVICAL CAVITY

- □ convulsions/stomach pains/astric pains around the navel
- □ feeling indigestible 2-3 hours after a meal
- □ fatigue after eating
- □ gases with rotten egg smell
- □ □ diarrhea/constipation
- □ locks in the stool
- □ glossy stool
- □ 3 or more large daily bowel movements
- □ dry, flaky skin, similarly to nails
- □ acne
- □ allergies
- □ low weight gain
- □ excessive reflections

GREUBE BOWEL

- □ seasonal diarrhoea
- □ inflammatory bowel diseases, diverticula, polyps
- □ urinary tract infections
- □ recurring vaginal ringworm/foot/nail/nail
- □ alternating between diarrhea/constipation
- □ flatulence, gass/pain on the right side/ pain on the left side: prickly/variable
- □ frequent antibiotic therapy throughout life
- □ loss of weight
- □ anemia
- □ gastrointestinal bleeding
- □ arthritis
- □ kidney stones
- □ irritable bowel
- □ blood hidden in the stool

LIVER, GALLBLADDER

- □ headaches, dizziness after eating
- □ fat intolerance
- □ light stools
- □ " stinking stools
- □ constipation
- □ hard stool
- □ painful bowel movements
- □ sour taste in the mouth after a meal
- □ grey skin, dry, yellow, dry
- □ hepatitis
- □ unpleasant body odour
- □ unpleasant odour from the mouth
- □ glacier
- □ lamp pains
- □ blood in the stool
- □ water retention

TARIFF

- □ intensive urine smell
- □ thick skin/nails
- □ dry skin
- □ cold hands/legs/sensitivity to cold
- □ excessive monthly bleeding
- □ chronic fatigue
- □ the problem with getting up in the morning
- □ depression, apathy
- □ low libido
- □ edematous skin
- □ sugar causes irritation, mood changes
- □ pre-menstrual voltage unit
- □ constipation
- □ pain, muscle stiffness
- □ thinning the eyebrows to 1/3 of the circumferential
- □ weight gain
- □ anemia not reacting to iron
- □ low body temperature
- □ infertility

ADRENAL GLANDS

- □ fatigue in the afternoon
- □ low pressure

- □ periodically constipated
- □ red eyes/itchy eyes
- □ hypersensitivity to chemicals, exhaust fumes
- □ intolerance of great effort
- □ bad tolerance of stress
- □ bad mood, bad mood, mood changes
- □ hair loss
- □ shadows under the eyes
- □ dizziness in standing position
- □ dispersion...
- □ infections following a change in the weather
- □ headaches
- □ respiratory problems
- □ hypersensitivity to bright light
- □ water retention
- □ water loss
- □ weakness, trembling

BONES

- □ back pain
- □ bone pains
- □ meat-rich diet
- □ cavities
- □ arthritis
- □ soda, proton pump blockers
- □ paradontosis
- □ bone loss
- □ the calcification of the tissues
- □ osteoporosis or osteoporosis or osteoporosis
- □ bone fracture
- □ after menopause

MUSCLES

- □ leg muscle spasms
- □ the tension in the shoulder blades
- □ pain
- □ rigidity
- □ seat problems
- □ back pain: lumbar-sacral/thoracic/frontal section

CONNECTING TISSUE

- □ excessive flexibility of joints

- □ back pain when leaning forward, sitting down, sitting down
- □ joint pain: knee/flat/shoulder/lbar/ wrist/foot fingers/ toes/arm fingers
- □ swelling of joints: knees/coats/boats/lbars/ wrists/foot fingers/arm fingers/fingers
- □ varicose veins/hemorrhoids
- □ disc problems

ALLERGIES, IMMUNOLOGY, METABOLISM

- □ arthritis in childhood
- □ hay fever/eye itching
- □ asthma
- □ frequent coughing
- □ skin lesions
- □ urticaria
- □ allergies to medication, if so, what kind of medication:
- □ allergy to food, if yes, to what foods:
- □ allergy to dust/dust
- □ allergies in the family
- □ fatigue during the day
- □ edema/shadows under the eyes
- □ □ hypersensitivity to chemicals
- □ □ migratory joint pain/muscle pain in a variable location
- □ excessive perspiration/lack of perspiration
- □ □ fever states/ temperature rises
- □ intolerance of wine/series/strawberries/tomatoes
- □ numbness, burning of hands/legs/language,
- □ loss of balance, body casting, insecure walking like drunk

IN AN INTERVIEW WITH THE EPISODES:

- □ depression/low mood
- □ fear/fear/phobia
- □ angry outbursts of anger
- □ stress in life
- □ emotional problems
- □ dispersion/ forgetfulness
- □ bad tolerance for changes in life, new circumstances, challenges = high stress
- □ fear of public speaking out
- □ learning difficulties/concentration
- □ hyperactivity
- □ frequent mood changes
- □ keeping grief in custody
- □ □ drowsiness

- □ insomnia/gunny thoughts before going to sleep/ability to relax the body/voltage
- □ muscle/joint pains
- □ excessive worrying
- □ historical mental/physical/sexual abuse

FAMILY DISEASES

- Mother and mother's family:
- Father and father's family:
- Siblings:
- Children:

How did you find out about your individual health plan?

I accept that:

1. The Institute of Functional Medicine with its seat in Warsaw at 31 Borsucza Street is the administrator of my personal data.
2. The Institute of Functional Medicine collects personal data in order to conclude and perform services related to the annual and semi-annual health plan.
3. I have the right to access the content of my data and correct them. Providing personal data is voluntary, but this data is necessary for the proper performance of the service.
4. I have the right to inspect my personal data stored by the Institute of Functional Medicine and to change or delete them. In order to change or delete my personal data, I will contact the Service Provider by e-mail at the following address: kontakt@imf.pl

☐ I agree to the processing of my personal data by IMF with its registered office in Warsaw, 31 Borsucza Street, in order to answer my questions, including the submission of an offer, if I ask for it. My personal data will be processed until the withdrawal of consent or for the period necessary to establish, enforce or defend claims. I have the right to access the data, rectify, delete or limit the processing, object, lodge a complaint to the supervisory authority and to transfer the data.

☐ I agree to the processing of my personal data provided above for marketing purposes.

Date and signature