HEALTH QUESTIONNAIRE

This Consultation Form will assist your practitioner in preparing advice about Regul8®.

All information is strictly confidential & remains the property of ______________________ (clinic name)

Please read the label of Regul8® and all dietary supplements before usage and consult your healthcare professional.

Name ______________________ D.O.B ______________________

Address ______________________ Weight ____________ Height ____________

Email ______________________ Measure waist circumference ______________________

Mobile ______________________ Measure around the buttocks ______________________

Please list your main health concerns ______________________

Current medical concerns:

☐ Cancer ☐ Diabetes ☐ Blood Pressure ☐ Heart Disease ☐ Hepatitis ☐ Seizures ☐ Kidney Stones

Other: ______________________

Please answer yes or no if you suffer from the following and give a rating of 0 to 10 on the severity.
0 being none, 5 indicates moderate, 10 indicates all the time.

	Please circle Y or N		Rating 0-10
Constipation	Y	N	____
Diarrhoea	Y	N	____
Alternating constipation & diarrhoea	Y	N	____
Irritable bowel syndrome	Y	N	____
Reflux	Y	N	____
Bad breath	Y	N	____
Nausea	Y	N	____
Gas	Y	N	____
Bloating after eating	Y	N	____
Crohn's Disease	Y	N	____
Diverticulitis	Y	N	____
Weight around the mid-section	Y	N	____
Find it hard to lose weight	Y	N	____
Insulin resistance, type 2 diabetes	Y	N	____
Abdominal pain	Y	N	____
Pain in the rectum/lower back pain	Y	N	____
Hay fever	Y	N	____

	Please circle Y or N		Rating 0-10
Rhinitis or sinusitis	Y	N	____
Asthma	Y	N	____
Bronchitis	Y	N	____
Cough	Y	N	____
Viruses	Y	N	____

Allergies may be an indication of compromised digestive health.

Food allergy, intolerance or sensitivity	Y	N	____

These are clues that indicate you are not digesting your food thoroughly, and the resulting immune reaction in your intestines is inflaming the delicate gut lining.

Skin problems like itchy skin	Y	N	____
Acne	Y	N	____
Rosacea	Y	N	____
Psoriasis	Y	N	____
Dermatitis	Y	N	____
Eczema	Y	N	____

If the skin on the outside of your body is inflamed, it may be indication that your skin on the inside is also inflamed.

Hair loss, thinning	Y	N	____

FOOD CRAVINGS

	Please circle Y or N		Rating 0-10
FOOD CRAVINGS	Y	N	____

If yes what type of food?

Average Daily Diet:

Morning ____

Afternoon ____

Evening ____

Do you feel tired after eating?	Y	N	____
Do you have an energy slump during the day?	Y	N	____

What time?

Habits (Please specify amount per day)

☐ Cigarettes ☐ Coffee ☐ Tea ☐ Cola ☐ Alcohol

☐ Drugs ☐ Sugar ☐ Salt ☐ Other (Please specify)

SLEEP

What time do you go to bed? ____

Do you sleep well?	Y	N	Sometimes
Do you wake easily and find it easy to get out of bed?	Y	N	Sometimes
Rate your energy levels			____

MOOD DISORDERS

Anxiety	Y	N	____
Easily stressed	Y	N	____
Depression	Y	N	____
Angry	Y	N	____
Bad temper	Y	N	____
Mood swings	Y	N	____
Attention Deficit Hyperactivity Disorder (ADHD)	Y	N	____

Harmful bugs in your intestines produce toxins that may travel right through your bloodstream and they may cross through your blood brain barrier. These toxins may disrupt the production of neurotransmitters in your brain and negatively affect your mood.

	Please circle Y or N		Rating 0-10
THYROID PROBLEMS	Y	N	____
Diagnosis of an autoimmune disease	Y	N	____

There is research to link between autoimmune disease and leaky gut syndrome. There are 81 recognised autoimmune diseases; the most common ones are Hashimoto's thyroiditis, rheumatoid arthritis and psoriasis.

Joint pain	Y	N	____

This may be a symptom of an inflamed gut. Toxins that enter the bloodstream through the gut lining typically lodge in the joints and create pain and inflammation.

MUSCLE PAIN

MUSCLE PAIN	Y	N	____

Where is the pain and is it fixed pain or stabbing?

Do you exercise?	Y	N	____

How many bowel movements do you have per week? ____

How many bowel movements do you have per day? ____

Do you use laxatives?	Y	N	____

CONTRAINDICATIONS

Please list any current medication

Medications taken in the last 6 months?

Please list any allergies

Are you pregnant or trying to get pregnant?	Y	N	____
Are you breastfeeding?	Y	N	____
Do you plan on having surgery?	Y	N	____

Please describe if you have suffered any illnesses or surgeries in the past 12 months?

Please describe any gynecological problems? PCOS, endometriosis, irregular periods? Menopause? Breast lumps?

Please list any health problems that have not been covered

Please advise any treatment plans or medical advice you have been given

CONSENT

I have completed my pre treatment medical history form and have informed my practitioner of any pre existing skin or other medical conditions or treatments or medicines.

Although AMARCO Enterprises Pty Limited, trading as Regul8® Pty Ltd, endeavours to ensure that all clients receive the best possible care and results, at no time does it make any guarantees or undertakings that any Regul8® treatment or product will cure, alleviate, prevent, eliminate, or retard any injury, illness or condition.

☐ I acknowledge that it is recommended that I consult with my healthcare professional before and whilst taking Regul8®.

PRIVACY POLICY

My personal information is used for the purpose of preparing information and advice about Regul8®.

I agree ☐ for my contact details be used to receive information about Regul8® including direct mailers and promotional materials

via email YES ☐ or NO ☐
and/or sms messages YES ☐ or NO ☐ about Regul8®.

I agree ☐ for my contact details to be used to receive promotions and other advertising by the clinic.

I understand that I have the right to request a copy of a Privacy Policy from the practitioner/clinic.

SIGN ____

DATE ____