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**Men’s Review Questionnaire**

***In preparation for your next appointment,***

***please complete online and email back prior to your visit.***

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| --- | --- | --- | --- | --- |
| Name : | | | Date : | Appointment # : |
| What has changed / happened since your last appointment?  What are you noticing (be specific)? | | |  | |
| What percentage improvement have you noticed overall? (0=none - 100% vast improvement) | | |  | |
| What percentage have you been on your dietary regime? (0=not - 100% strictly on it) | | |  | |
| What percentage have you been on your supplement regime?  (0=not - 100% strictly on it) | | |  | |
| Have you or are you seeing any other practitioners since your last visit? (If so, who & what for?) | | |  | |
| Have you stopped or started any supplements or medications? | | |  | |
| What supplements are you taking presently? | | |  | |
| What is your focus for your next appointment? | | |  | |
| What is your end goal? | | |  | |
| What is obstructing or preventing this? | | |  | |
| What has been successful in your treatment so far, what are the positives? | | |  | |
| What has not been successful yet, what are the negatives? | | |  | |
| **Please rate your:** | **0-10** | **RATE OUT OF TEN – 1 = low / 10 = high. Comments** | | |
| Energy levels |  |  | | |
| Stress |  |  | | |
| Anxiety |  |  | | |
| Depression |  |  | | |
| Melancholy |  |  | | |
| Sleep quality |  |  | | |
| Average hours of sleep |  |  | | |
| Number of times you wake |  | What time/s do you wake?  Time taken to go back to sleep - | | |
| Mental Clarity / memory |  |  | | |
| Other |  |  | | |
| Bowel function overall (well formed & easy to pass / loose / diarrhoea / lots of wind / mucus / constipated / other |  |  | | |
| How often do you have a bowel motion...  A number of times a day / daily / every other day / weekly / other : |  |  | | |
| Do you have Haemorrhoids? |  |  | | |
| Skin |  |  | | |
| Night sweats |  |  | | |
| Bloating |  |  | | |
| Wind / flatulence. |  | Is *it Odorous?* | | |
| Sense of Wellbeing |  |  | | |
| Was your diet |  |  | | |
| Weight |  |  | | |
| Irritability |  |  | | |
| Moodiness |  |  | | |
| Teariness / Emotionality |  |  | | |
| Frustration / Irritability |  |  | | |
| Sugar cravings |  |  | | |
| Libido |  |  | | |
| Migraine |  |  | | |
| What exercise are you doing & how much?  Rate the intensity MILD/MODERATE/HIGH |  | | | |
| **BODY PAIN / DISCOMFORT : Please rate where 1 = low / 10 = high.** | | | | |
| Muscle tension / hardness / knots |  |  | | |
| Body pain |  |  | | |
| Headaches   * intensity |  |  | | |
| Neck & Upper Shoulders |  |  | | |
| Middle Back |  |  | | |
| Lower Back |  |  | | |
| Legs |  |  | | |
| Arms & shoulders |  |  | | |
| Joints |  |  | | |
| Legs & feet |  |  | | |
|  | | | | |

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| --- | --- |
| **Medical Update** - are there any medications you have started or stopped, or any medical appointments you have attended since your last visit? |  |
| Have you seen any other health care professionals, started or stopped any supplements, herbs or other Natural remedies? |  |
| How many Neurofen, Panodol, Antibiotics or other over the counter medicines have you used since your last appointment? |  |

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| **COVID-19 INFO:**  Have you have had the COVID-19 vaccine? If yes, what dates?  If no, are you planning to have it?  Have you been in close proximity to someone who has taken this vaccine (eg: partner, close contacts)?  **PCR TEST:**  Have you had a PCR Covid test? How many and what dates?  Have you had Covid-19 or tested positive on a PCR test? |

Is there anything else?