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Signs & Symptoms Questionnaire

For Cell Nutrition use only

Private and confidential

Please carefully read and complete this check list marking every line according to what applies to you.

If you have any of the following symptoms you must report it to your GP/medical doctor. Nutritional Therapists practicing according to the BANT and CNHC codes of practice are not authorized to diagnose medical conditions nor offer treatment in replacement of medical care.

Please make sure you sign and date all pages at the bottom.

Pain – Do you have	yes	no	
Any pain which is persistent, particularly if severe or in the head, abdomen or ce (please define which):	ntral chest?		
Pain in the eye or temples, with local tenderness?			
Pain on passing urine?			
Recurrent cystitis? (How many times have you had it?)			
Absence of pain in skin ulcers, fissures?			
Sciatic pain with neurological deficit?			
Bleeding – have you noticed	yes	no	
Blood in sputum, vomit, urine or stools?			
Vomit containing "coffee grounds", coagulated blood?			
Black, tarry stools?			
Vaginal bleeding with pain?			
Is your GP aware of the symptoms marked here with a Yes? If not, specify which	yes	no	
Client full name:			
Client signature: Date	te:		
Signs & Symptoms Questionnaire		v 1.0	
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Deep depression, suicidal ideas? Hearing voices? Delusional beliefs? Incongruous behaviour? Do you ever get sudden Breathlessness? Swelling of face, lips, tongue or throat? Blueness of the lips? Loss of consciousness? Loss of voision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Ves no Client full name: Client full name: Date: Date:	Psychological – do you suffer from		yes	no
Delusional beliefs? Incongruous behaviour? Do you ever get sudden Breathlessness? Swelling of face, lips, tongue or throat? Blueness of the lips? Loss of consciousness? Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date: Date:	Deep depression, suicidal ideas?			
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Do you ever get sudden Breathlessness? Swelling of face, lips, tongue or throat? Blueness of the lips? Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Unexplained behavioural change? Breathing? Breathing? Breathing? Have you noticed a change yes no lin bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client full name: Client signature: Date:	Delusional beliefs?			
Do you ever get sudden Breathlessness? Swelling of face, lips, tongue or throat? Blueness of the lips? Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Unexplained behavioural change? Breathing? Breathing? Breathing? Have you noticed a change yes no lin bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client full name: Client signature: Date:				
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Breathlessness? Swelling of face, lips, tongue or throat? Blueness of the lips? Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty yes no Swallowing? Breathing? Have you noticed a change in bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date:				
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Blueness of the lips? Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date:	Breathlessness?			
Loss of consciousness? Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date: Date:	Swelling of face, lips, tongue or throat?			
Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date:	Blueness of the lips?			
Loss of vision? Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date:	Loss of consciousness?			
Convulsions/fits? Unexplained behavioural change? Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature: Date:	LOSS OF COMBUICASE:			
Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:	Loss of vision?			
Do you have difficulty Swallowing? Breathing? Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? It syour GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:	Convulsions/fits?			
Swallowing? Breathing? Have you noticed a change yes no in bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no in the symptoms marked here with a Yes? If not, specify which yes no in the symptoms marked here with a Yes? If not, specify which in the symptom	Unexplained behavioural change?			
Swallowing? Breathing? Have you noticed a change yes no in bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no in the symptoms marked here with a Yes? If not, specify which yes no in the symptoms marked here with a Yes? If not, specify which in the symptom				
Breathing? Have you noticed a change yes no in bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which yes no Client full name: Client signature:	Do you have difficulty		yes	no
Have you noticed a change In bowel habit? In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:	Swallowing?			
In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:	Breathing?			
In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:				
In a skin lesion (size, shape, colour, bleeding, itching, pain)? Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Client signature: Date:	Have you noticed a change		ves	no
Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Date:	In bowel habit?		, , , ,	
Is your GP aware of the symptoms marked here with a Yes? If not, specify which Client full name: Date:	In a skip losion (size shape colour blooding itshing pain)?			
Client full name: Client signature: Date:	in a skin lesion (size, snape, colour, bleeding, itching, pain)?			
Client full name: Client signature: Date:			.	•
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Client signature: Date:	Is your GP aware of the symptoms marked here with a Yes? If not, spec	ify which	yes	no
Client signature: Date:				
Client signature: Date:				
Client signature: Date:				
Client signature: Date:	Client full name			
	Client full name:			
	Client signature:	Date:		
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Do you have persistent		yes	no
Vomiting &/or diarrhoea?			
Thirst?			
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Increase in time passing urine?			
Cough?			
Unexplained loss of weight (1 lb per week or more)?			
Other signs and symptoms		yes	no
Do you suffer from pallor?			
Do you notice unexplained swelling or lumps anywhere?			
Do you have neck stiffness associated with fever?			
Do you suffer from unexplained recurrent or persistent fever?			
Do you have brown patches around the body?			
Women only		yes	no
Are you pregnant?			
Are you trying for a baby?			
If you are pregnant, how many weeks into the pregnancy are you?			
What form of contraception do you use?			
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Is your GP aware of the symptoms marked here with a Yes? If not, specify wh	ich	yes	no
		<u> </u>	<u> </u>
Client full name:			
Client signature:	Date:		