H Pylori Symptoms

Gut Buddies Packages for optimal digestion, energy, mood and skin.

Dear Sir or Madam,

Thank you for your enquiry! It is truly our goal to become your partner in achieving optimal health and vitality.

Please take a few moments to read the enclosed information explaining the nature and processes of our Nutrition, Lifestyle and Functional Medicine programmes and how this work will bring benefit to you.

The key to Functional Medicine is that we work with you as an individual and strive to understand the root cause of your symptoms. This generally entails a detailed set of paperwork that we require you to complete and return to us, followed by an in depth conversation about your current state of health, health history, family history, diet, lifestyle habits, etc.

Initial consultations last approximately 60-75 minutes and are primarily information gathering and sharing sessions. We will certainly make some simple diet, lifestyle and reading recommendations at this time, but some advice will be deferred until after lab results are in and there has been time to thoughtfully consider your case.

Your second consultation is generally scheduled when lab results are returned to us. It is at that time that we will discuss and review the findings whilst making further diet and lifestyle amendments and discussing nutritional supplementation that will help you. We may also refer you to your physician should we feel that you may benefit from any prescription medications (usually to remove parasites and bacterial infections that cannot be dealt with using herbs).

Follow-up calls can be scheduled daily, weekly, fortnightly or monthly, depending on the level of ongoing support we agree you will benefit most from. We ask you for an initial commitment to your programme of 90-days because that is generally the length of time that guarantees noticeable and tangible benefits. Some symptoms my clear much faster than this and some may take longer. It all depends on what is causing your symptoms.

Following your initial 90-day programme you may wish to continue working with us on an ongoing basis or you may choose to continue progressing on your own. This is your choice and will depend on the progress you make in the initial 90-days.

If you have any further questions after reading the enclosed information, please call or email our office. We will be happy to assist you. Please be sure to complete all required forms and return them to our office prior to your initial consultation.

We look forward to working with you.

In health,

Dave Hompes and Staff.

Dave Hompes Health For The People Ltd. 35 Kingsland Road, London, E2 8AA
Tel: **0800 310 21 21 (UK)** • Fax: **(+44) 2079045733** • **www.h-pylori-symptoms.com** • **office@hpexperts.com**

Registered in England &Wales, Company No. 6955670. VAT Number 997294742

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Gut Buddies Packages for optimal digestion, energy, mood and skin.

Please print or complete all sections on your computer, then return the forms by email, post or fax!

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

Name:				Date:
Address:				Country:
Town/City:		County/State:		Zip/Postal Code:
Home Phone:		Work Phone:		Fax:
E-mail:			Cell Phone:	
Please mark your preference for occasional follow up communication from our office: Email *or* Phone				
Age:	Birth date:	Sex: M F	Status: M S W D	No. Children:
Occupation:		Employer:		Years Employed:
Spouse's Name:		Occupation:		Employer:
Person responsible for this account:				Referred by:
What is your major complaint?				
Other complaints?				
What are your overall health goals once your complaints are resolved?				
How long has it been since you really felt good?				

Client / Patient's Signature: ..... Date: .....

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Please answer all questions frankly and to the best of your knowledge.
All information is confidential.

Weight: ..... Height: ..... Blood Pressure (if known): ..... % Body Fat (if known): .....

1. Are you presently taking any medications, nutritional supplements or vitamins? ☐ YES ☐ NO

Please list (attach sheet if necessary)

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2. In the past, have you used birth control pills and/or antibiotics? ☐ YES ☐ NO

a. For how long?

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3. If you have fillings, please list material(s) used:

.....

.....

4. Do you presently, or have you ever had any of these conditions? (Please ✓ tick)

☐ Anemia	☐ Frequent Headaches	☐ Skin condition
☐ Arthritis	☐ Heartburn	☐ Thyroid condition
☐ Asthma	☐ High blood pressure	☐ Unexplained weight change
☐ Chest pains	☐ High cholesterol	☐ Heart disease
☐ Chronic cold/flu symptoms	☐ Hypoglycemia	☐ Cancer
☐ Chronic fatigue	☐ Kidney problems	☐ Fibromyalgia
☐ Depression	☐ Liver problems	☐ Lupus
☐ Diabetes	☐ Osteoporosis	
Other (please list):		

5. How much sleep do you get each night on average? ..... hours

6. Do you have any food allergies, sensitivities or restrictions? ☐ YES ☐ NO

7. Do you smoke, drink alcohol or use recreational drugs? ☐ YES ☐ NO

a. How much, how often?

.....

b. How often do you drink caffeinated beverages?

.....

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.):

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9. Are there foods that you eat on a daily basis, almost daily basis?

.....

.....

a. Do you “miss” these foods if you do not eat them? ☐ YES ☐ NO

10. Write briefly about your weight gain/loss history:

.....

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.....

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.....

.....

a. What do you feel triggered your weight fluctuation? (Please ✓ tick)

☐ heredity ☐ stress ☐ eating habits ☐ boredom

b. Was your weight gain/loss: (Please ✓ tick)

☐ sudden ☐ gradual ☐ problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity:

.....

.....

.....

.....

.....

.....

12. What methods have you tried to lose/gain weight?

.....

.....

.....

.....

.....

.....

13. How is your energy level?

.....

a. Are there times in the day that you feel…

best:.....

worst: .....

14. Are you happy in your life right now? ☐ YES ☐ NO

15. What are your main sources of stress?

.....

.....

.....

.....

16. How do you deal with your stress?

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17. Please answer the following questions **Yes** or **No**: (Please ✓ tick)

a. If I'm feeling down, a snack makes me feel better. ☐ YES ☐ NO

b. I sometimes have a hard time going to sleep without a bedtime snack. ☐ YES ☐ NO

c. I get tired and/or hungry in the mid-afternoon. ☐ YES ☐ NO

d. I get a sleepy, almost 'drugged' feeling after eating a meal containing bread, pasta or dessert. ☐ YES ☐ NO

e. Now and then I think I am a secret eater. ☐ YES ☐ NO

f. At a restaurant, I almost always eat too much bread before the meal is served. ☐ YES ☐ NO

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. ☐ YES ☐ NO

h. I experience cravings for sugar, breads, pasta and baked goods. ☐ YES ☐ NO

i. I feel shaky if I don't eat on time or if I don't snack. ☐ YES ☐ NO

j. I often find myself irritable or angry. ☐ YES ☐ NO

18. Check off any of the following that have applied to you <u>within the last 30 days:</u>

Do you feel nauseous?	Do you have abdominal/intestinal pain?
Do you have bloating?	Do you get bloated after meals?
Do you get heartburn?	Do you have diarrhea?
Do you have constipation?	Do you travel to / holiday in developing countries?
Do you have gas?	Are your stools compact/hard to pass?
Do you belch following meals?	Do you have gurgles in your stomach?
Do your bowel movements alternate between constipation and diarrhea?	

19. In your estimation, how physically fit are you right now? (Please ✓ tick)

☐ Unfit ☐ Below average ☐ Average ☐ Above average ☐ Very fit

20. How often do you exercise?

.....

a. What is your regime?

.....

.....

21. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

.....

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22. What are your fitness goals? (Check all that apply)

General fitness endurance	Muscle toning
Weight loss/maintain weight	Muscle strengthening
Osteoporosis prevention	Muscular coordination/balance
Specific sport enhancement	Flexibility
Other:	

23. Surgeries, starting with most recent:

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24. Hospitalizations:

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25. Briefly describe where you have lived since childhood:

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26. What is your heritage? (Irish, German, Spanish, etc.)

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27. Please ✓ tick “Now” or “Past” for only those items with which you identify.
(Ignore anything that does not apply to you.)

Is your life:	Do you often:
☐ Now ☐ Past Satisfactory	☐ Now ☐ Past Feel depressed
☐ Now ☐ Past Boring	☐ Now ☐ Past Have anxiety
☐ Now ☐ Past Demanding	Do you often:
☐ Now ☐ Past Unsatisfactory	☐ Now ☐ Past Have irrational fears
Do you worry over:	☐ Now ☐ Past Feel upset
☐ Now ☐ Past Home life	☐ Now ☐ Past Feel things go wrong
☐ Now ☐ Past Marriage	☐ Now ☐ Past Feel shy
☐ Now ☐ Past Children	☐ Now ☐ Past Cry
☐ Now ☐ Past Job	☐ Now ☐ Past Feel inferior
☐ Now ☐ Past Income	Have you:
☐ Now ☐ Past Money problems	☐ Now ☐ Past Seriously considered suicide
	☐ Now ☐ Past Attempted suicide

Rate on a scale of: **5 = very willing** to **1 = not willing**:

In order to improve your health, how willing are you to:

a. Modify your diet _____

b. Take nutritional supplements each day _____

c. Keep a record of everything you eat each day _____

d. Modify your lifestyle (e.g. work demands, sleep habits) _____

e. Practice relaxation techniques _____

f. Engage in regular exercise _____

g. Have periodic lab tests to assess progress _____

Comments:

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Rate on a scale of: **5 = very confident** to **1 = not confident at all**:

How confident are you of your ability to organize and follow through on the above health related activities?

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

.....

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.....

Rate on a scale of: **5 = very supportive** to **1 = not supportive at all**.

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

Comments:

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Rate on a scale of: **5 = very frequent contact** to **1 = very infrequent contact**.

How much ongoing support and contact (e.g. telephone consults, e-mail correspondence) from your professional staff would be helpful to you as you implement your personal health program?

Comments:

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.....

Please see next page for details on how to return your completed form…

Thank you for taking the time to complete this health history questionnaire. The information derived from all of these forms will provide invaluable data. Each section builds upon the other, allowing me and other physicians the opportunity to discover the "missing key" that will solve your health problem. Once all the sections of this form and the questionnaires have been filled out please return them to our office and we'll make an appointment for our initial consultation. I thank you once again and look forward to helping you achieve a "return to health and well being."

Sincerely,

Dave Hompes & all at Health For The People Ltd.

Please return your completed form using one of the following:

Email: Office@HPExperts.com

Fax: +44 207 904 5733

Post: 35 Kingsland Road, London, E2 8AA, England