

Questionnaire



Here are some of the symptoms which Hilary has helped over the past 20 years, download the questionnaire below to see how many of the following you are experiencing. Fill this Questionnaire in, scan and return it to: info@thinknutrition.co.uk.

Name:

Email:

Age:

Gender:

<input type="checkbox"/> Bloating	<input type="checkbox"/> Heart problems
<input type="checkbox"/> Digestive problems	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Indigestion	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Reflux	<input type="checkbox"/> Stress related illness
<input type="checkbox"/> Burping	<input type="checkbox"/> Poor concentration
<input type="checkbox"/> Stomach pains	<input type="checkbox"/> Poor memory / forgetfulness
<input type="checkbox"/> Constipation	<input type="checkbox"/> OCD
<input type="checkbox"/> Diarrhoea	<input type="checkbox"/> ADHD or behavioural difficulties
<input type="checkbox"/> Stress or hectic lifestyle	<input type="checkbox"/> Cold sores
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Frequent colds
<input type="checkbox"/> Irritable Bowel (IBS or IBD)	<input type="checkbox"/> Chest infections
<input type="checkbox"/> Puffy / bags under the eyes	<input type="checkbox"/> Sore throats
<input type="checkbox"/> Low libido	<input type="checkbox"/> Flatulence
<input type="checkbox"/> Cold hands or feet	<input type="checkbox"/> Wind
<input type="checkbox"/> PMS	<input type="checkbox"/> Bloating
<input type="checkbox"/> Infertility	<input type="checkbox"/> Beer Belly
<input type="checkbox"/> Thrush	<input type="checkbox"/> Insomnia / Inability to sleep
<input type="checkbox"/> Cystitis	<input type="checkbox"/> Low energy levels or tiredness
<input type="checkbox"/> Athletes foot	<input type="checkbox"/> Extreme fatigue
<input type="checkbox"/> Dandruff	<input type="checkbox"/> Exhaustion
<input type="checkbox"/> Allergies	<input type="checkbox"/> Burnout
<input type="checkbox"/> Sinus or mucous problems	<input type="checkbox"/> Cravings
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sweating or thirst or frequent urination
<input type="checkbox"/> Breathing difficulties	<input type="checkbox"/> Prostate concerns
<input type="checkbox"/> Hayfever	<input type="checkbox"/> Endometriosis / Polycystic Ovaries / Fibroids
<input type="checkbox"/> Bad breath	<input type="checkbox"/> Irregular smear test
<input type="checkbox"/> Brittle nails or hair	<input type="checkbox"/> Ageing (face, body)
<input type="checkbox"/> Anal irritation	<input type="checkbox"/> Easily irritated /angered
<input type="checkbox"/> Carbohydrate or sugar/chocolate cravings	<input type="checkbox"/> Depression / feeling 'blue'
<input type="checkbox"/> Constant hunger	<input type="checkbox"/> Headaches / migraines
<input type="checkbox"/> Dry Skin or Eczema	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Rashes	<input type="checkbox"/> Dizzy spells
<input type="checkbox"/> Itchy Skin	<input type="checkbox"/> Panic attacks
<input type="checkbox"/> Spots or acne	<input type="checkbox"/> Restless leg / muscle weakness
<input type="checkbox"/> Hair Loss / Alopecia	<input type="checkbox"/> Aching joints
<input type="checkbox"/> Brain fog	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Coated Tongue	<input type="checkbox"/> Joint pain
<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Creamy or yellow instead of bright white of your eyes	<input type="checkbox"/> Menopausal symptoms (osteoporosis, sweats, weight gain)
<input type="checkbox"/> Hard to get up in the morning	<input type="checkbox"/> Poor tolerance to alcohol
<input type="checkbox"/> Energy dips during the day	<input type="checkbox"/> Dental problems
<input type="checkbox"/> Food poisoning	<input type="checkbox"/> Back pain
<input type="checkbox"/> Symptoms after foreign travel	<input type="checkbox"/> Varicose veins
<input type="checkbox"/> Anorexia or Bulimia now or in the past	<input type="checkbox"/> Virus
<input type="checkbox"/> Inflammatory disorders	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Cancer / cell changes, now or in the past	<input type="checkbox"/> Weight Gain for no reason
<input type="checkbox"/> Autoimmune disease	<input type="checkbox"/> Water Retention