***Consultation’s date:***

***Interview***

1. **Personal data:**
* Name:
* Age:
* Weight and height:
* Adress:
* Mail:
* Phone number:
* Login skype:
* Your goals?

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| **Metabolism** |
| What is your fasting glucose level? |  |
| What is your fasting insulin level? |  |
| Do you have problems with weight?  | Yes/ Not |
| Do you have diabetes? (I or II) | Yes/ Not |
| Has anyone in your family had diabetes?  | Yes/ Not |
| Do you have energy drop after meals? | Yes/ Not |
| Do you need a nap during the day?  | Yes/ Not |
| Are you addicted to sweets or fastofoods?  | Yes/ Not |
| Do you have cold feet and hands?  | Yes/ Not |
| Do you have swelling?  | Yes/ Not |
| Do you have fatty liver disease?  | Yes/ Not |
| How high is your blood pressure?  |  |
| Comment:  |  |

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| **Detox/allergies** |
| Do you have allergies or intolerance for food? To which ones?  |  |
| Do you have allergy for cosmetics?  | Yes/ Not |
| Do you work with toxins/chemicals?  | Yes/ Not |
| Do you drink alcohol? How often?  | Yes/ Not |
| Do you smoke cigarretes?  | Yes/ Not |
| Do you have mold in your home?  | Yes/ Not |
| Do you use air fresheners?  | Yes/ Not |
| Do you have problem with excessive sweating?  | Yes/ Not |
| Do you have skin problems? (acne/eczema/allergies)?  | Yes/ Not |
| Are you hypersensitive for strong smells?  | Yes/ Not |
| Do you have headache? How often?  | Yes/ Not |
| Comment:  |  |

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| **Problems with stomach and bowels**  |
| Do you have stomachache?  | Yes/ Not |
| Do you have intestinal pain?  | Yes/ Not |
| Do you have bloating?  | Yes/ Not |
| Do you have diarrhea?  | Yes/ Not |
| Do you have SIBO?  | Yes/ Not |
| Do you have constipations?  | Yes/ Not |
| How often do you go do toilet? And when? |  |
| Do you have problem with caries?  | Yes/ Not |
| Do yu have Helicobacter pylori? | Yes/ Not |
| Do you have any diagnosed diseases, such as Crohn's disease/colitis/ulcers/erosions? |  |
| Comment:  |  |

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| **Mood problems/sleep problems** |
| Which time do you go to sleep? Which time do you wake up?  |  |
| Do you have trouble falling asleep?  | Yes/ Not |
| How often do you wake up in the night?  | Yes/ Not |
| Do you have dreams during night? (REM phase)  | Yes/ Not |
| Do you feel regenerated in the morning?  | Yes/ Not |
| Are you shift-worker? (especially at night) | Yes/ Not |
| Do you have enough energy during day? | Yes/ Not |
| How often do you expose yourself to sunlight?  | Yes/ Not |
| Do you turn off WIFI at night? | Yes/ Not |
| Do you watch TV before sleep?  | Yes/ Not |
| Do you learn new things quickly?  | Yes/ Not |
| Can you start your day without coffee?  | Yes/ Not |
| Do you have some free time for you during the day?  | Yes/ Not |
| Are you perfectionist?  | Yes/ Not |
| Do you have problems with memory?  | Yes/ Not |
| Do you experience anxiety?  | Yes/ Not |
| Do you feel tired when you reading books?  | Yes/ Not |
| Do you think that you are more susceptible for stress?  | Yes/ Not |
| Do you have need to eat something sweet or unhealthy after episode of stress?  | Yes/ Not |
| Was there a history of addiction in your family? | Yes/ Not |
| Has anyone in your family suffered from mood disorders/neurological disorders (schizophrenia/Alzheimer's/Parkinson's/depression)? | Yes/ Not |
| Comment:  |  |

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| **Hormonal problems (women)**  |
| Do you have regular periods?  | Yes/ Not |
| Do you have painful periods?  | Yes/ Not |
| Do you have strong PMS symptoms?  | Yes/ Not |
| Do you have problems with mood before periods?  | Yes/ Not |
| Do you have abundant body hair? | Yes/ Not |
| Have you already gone through menopause? | Yes/ Not |
| Do you have a lot of permanent stress?  | Yes/ Not |
| Do you have problem with libido?  | Yes/ Not |
| Do you have any of the following diseases (check the correct one)? Endometriosis/PCOS/uterine fibroids/breast cancer/genital cancer/low all hormones/fertility problems |  |
| Do you have problem to lose fat?  | Yes/ Not |
| Do you plan a pregnancy in the near future?  | Yes/ Not |
| Comment:  |  |

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| **Hormonal problems (men)** |
| Do you have problem with motivation?  | Yes/ Not |
| Do you have problem with libido/erection?  | Yes/ Not |
| Do you have problem with energy?  | Yes/ Not |
| Did you use any hormones? (testosterone etc.) | Yes/ Not |
| Do you suffer from any hormonal disorders diagnosed by your doctor? | Yes/ Not |
| Comment:  |  |

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| **Autoimmune diseases/problems with immunity** |
| Do you suffer from any autoimmune disease? (Hashimoto/RA/lupus/systemic sclerosis…) |  |
| Do you have joints pain?  | Yes/ Not |
| Does anyone in your family suffer from any autoimmune disease? | Yes/ Not |
| Have you had any miscarriages? | Yes/ Not |
| How often do you have flu or cold? | Yes/ Not |
| Do you have fever?  | Yes/ Not |
| Did you take a lot of antibiotics?  | Yes/ Not |
| Do you have mercury/amalgam fillings? | Yes/ Not |
| Do you often have clogged sinuses? | Yes/ Not |
| Do you have any allergies? | Yes/ Not |
| Do you suffer from asthma?  | Yes/ Not |
| Do you have infections (Lyme disease/babesiosis/bartonella/chlamydia/mycoplasma/EBV/Hepatitis/CMV/HPV/parasites/lambia)? (mark) | Yes/ Not |
| Comment:  |  |

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| **Medicines and supplements** |
| Do you take any drugs? (Which?) |  |
| Do you take any supplements?  |  |

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| **Diet** |
| Do you currently follow any diet (ketogenic/paleo/vegetarian/samurai/high-carbohydrate/Dukan/Mimicking fasting/other)? How long? (describe next to it) |  |
| Do you eat a lot of vegetables?  | Yes/ Not |
| Do you pay attention to the ingredients of food products? Do you read labels? | Yes/ Not |
| Do you eat a lot of sweets/fast foods? | Yes/ Not |
| What fats do you use in the kitchen? (rapeseed oil/sunflower oil/olive oil/coconut oil/butter/avocado oil/lard/other |  |
| Do you eat a lot of bread? White? Dark?  |  |
| Do you eat meat? | Yes/ Not |
| Do you feel the need to snack during the day? How often? | Yes/ Not |
| Are there any products you cannot tolerate (allergies/intolerances/your own observations)? (replace) |  |
| Are there any products you don’t like to eat? |  |
| How much do you drink water? |  |
| Do you drink any herbs/teas?  |  |
| Do you drink coffee? How much? How often?  |  |
| Comment:  |  |

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| **Sample menu** |
| Breakfast: |
| Lunch: |
| Dinner: |
| Snacks? |
| Supper: |

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| **Sport and activities** |
| Do you do any sports? |  |
| Your word mode: sitting/moving/moderate moving |  |
| Do you active during day? (steps/spontaneous activity) | Yes/ Not |
| What do you eat before/after training?  |  |
| Your regeneration is good after training?  | Yes/ Not |
| How often do you exercise? What time?  |  |

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| **Cancer diseases**  |
| Do you currently suffer from any cancer? What type? |  |
| What is the treatment like? (chemotherapy/radiotherapy/other) How long? |  |
| Are you currently experiencing any side effects from your treatment? (nausea/lack of appetite/rapid weight loss/diarrhea)? (describe next to it) |  |
| Did you have surgery to remove the tumor? | Yes/ Not |
| Have you ever used any diet to support treatment? | Yes/ Not |
| Are you under the care of a psychologist? | Yes/ Not |
| Has anyone in your family suffered from cancer? | Yes/ Not |
| Comment: |  |

**How do you see our cooperation?**

* Diet and supplement’s protocol.
* Just consultation.
* General nutritional recommendations with supplements.

**Własnoręczny podpis**

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