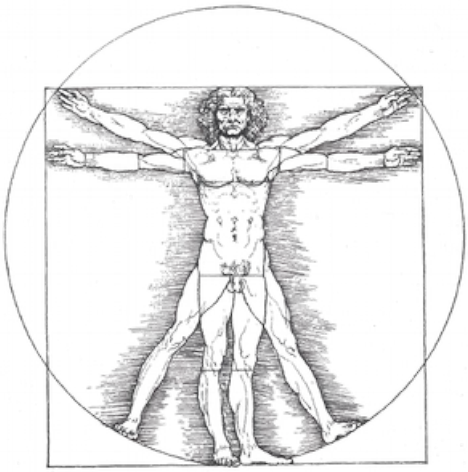

Gabriele Ottosson
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Hälsans Hus
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N.B: Fill just in the information you are comfortable with.

PERSONAL INFORMATION

Patient name: _____

Height: _____ cm

Weight: _____ kg

GENERAL INFORMATION

Did you lose weight in the last 10 years?

○ Yes○ No

Did you gain weight in the last 10 years?

○ Yes○ No

Have you ever smoked?

○ Yes○ No

Are you smoking now?

○ Yes○ No

If yes, how much do you smoke daily? _____

Does it bother you if someone smokes in your environment?

○ Yes○ No

Are you sensitive to perfume/fragrances?

○ Yes○ No

DISEASE HISTORY

Have you got or did you have any of the following diseases?

Parasites	○ Yes○ No
Diphtheria	○ Yes○ No
Whooping cough	○ Yes○ No
Measles	○ Yes○ No
Rubella	○ Yes○ No
Mumps	○ Yes○ No
Mononucleosis	○ Yes○ No
Inflammation of the liver (Infectious Hepatitis)	○ Yes○ No
Tuberculosis	○ Yes○ No
Venous disease	○ Yes○ No
Heart disease	○ Yes○ No
Blood circulation problems	○ Yes○ No
Diseases/disorders of the nervous system	○ Yes○ No
Blood pressure problems	○ Yes○ No
Vascular diseases	○ Yes○ No
Stroke	○ Yes○ No
Rheumatism	○ Yes○ No
Nerves and mood disorders	○ Yes○ No
Cramps (epilepsy)	○ Yes○ No

Eye diseases? If yes, please mention these below.

Diabetes ○ Yes○ No

Elevated blood fats (Cholesterol, Triglycerides) ○ Yes○ No

Elevated liver function tests ○ Yes○ No

Thyroid Diseases ○ Yes○ No

Urinary related diseases ○ Yes○ No

Genital diseases ○ Yes○ No

Kidney diseases ○ Yes○ No

Stomatitis ○ Yes○ No

Esophagitis ○ Yes○ No

Gastritis/ throat ulcer ○ Yes○ No

Crohn's disease (ileit term) ○ Yes○ No

Diverticula ○ Yes○ No

Ulcerative colitis ○ Yes○ No

Irritated bowel ○ Yes○ No

Gallbladder related diseases/gallstones ○ Yes○ No

Pancreatic inflammation ○ Yes○ No

Inguinal, scar and/or umbilical hernia? ○ Yes○ No

Liver diseases? If yes, please mention these below.

Respiratory diseases ○ Yes○ No

Hay fever ○ Yes○ No

Chronic bronchitis ○ Yes○ No

Asthma/COPD ○ Yes○ No

Pneumonia ○Yes ○ No

Tumor diseases ○ Yes○ No

Cancer ○ Yes○ No

Benign tumor? If yes, please mention these below.

Spinal diseases ○ Yes○ No

Undergone cancer screening? If yes, please mention it below.

Have you received vaccinations? If yes, please attach a copy of vaccination certificate.

○ Yes○ No

Did you have vaccination complications? If yes, please indicate below which one.

Gengivitis ○ Yes○ No

Inflammation of the tooth root ○ Yes○ No

Do you currently have amalgam fillings? If yes, please enter below how many.

Have you previously had amalgam fillings? If yes, please enter below how many.

Gold fillings ○ Yes○ No

Other metals ○ Yes○ No

Dead teeth ○ Yes○ No

Root canals ○ Yes○ No

Pivot teeth ○ Yes○ No

Dental implants ○ Yes○ No

Tooth crowns ○ Yes○ No

Previous or current braces ○ Yes○ No

Problems with chewing ○ Yes○ No

During one/more operation(s) was a metal implant inserted? If yes, please enter

Do you have allergies? If yes, please attach a certificate and indicate the allergy below.

Do you have kids? If yes, please write below how many.

Was the birth complicated or did it occur like miscarriage? If yes, please write

Other diseases? If yes, please mention these below.

○ Yes○ No

GENERAL SENSITIVITY

How do you feel generally?
○ Very good ○ Good ○ Ok ○ Bad ○ Very bad

Performance difficulties ○ Yes ○ A Little ○ No

Indifference ○ Yes ○ A Little ○ No

Concentration difficulties ○ Yes ○ A Little ○ No

Difficulties with memory ○ Yes ○ A Little ○ No

Chronic Fatigue ○ Yes ○ A Little ○ No

Worry / Anxiety / Panic Disorder ○ Yes ○ A Little ○ No

Do you often feel cold? ○ Yes ○ A Little ○ No

Hot flashes ○ Yes ○ A Little ○ No

Are you sweating a lot at night? ○ Yes ○ A Little ○ No

Loss of appetite ○ Yes ○ A Little ○ No

Weight changes ○ Yes ○ A Little ○ No

Water retention ○ Yes ○ A Little ○ No

Loss of libido ○ Yes ○ A Little ○ No

Obtains single inflammations ○ Yes ○ A Little ○ No

Cardiac and / or circulatory disorders ○ Yes ○ A Little ○ No

Drum or black in front of the eyes ○ Yes ○ A Little ○ No

Palpitation ○ Yes ○ A Little ○ No

Density in the chest ○ Yes ○ A Little ○ No

Other cardiac and / or circulatory problems: Write below

Urinary tract discomfort ○ Yes ○ A Little ○ No

Pain and / or burning sensation in urination ○ Yes ○ A Little ○ No

Severe urethra (more than 1x at night) ○ Yes ○ A Little ○ No

Involuntary / Spontaneous urination or stress ○ Yes ○ A Little ○ No

Breathing Problem ○ Yes ○ A Little ○ No

Cough (except for colds or allergies) ○ Yes ○ A Little ○ No

Hoarseness (with the exception of colds or allergies) ○ Yes ○ A Little ○ No

Misery at rest and / or work ○ Yes ○ A Little ○ No

Asthmattacks ○ Yes ○ A Little ○ No

Nosebleeds ○ Yes ○ A Little ○ No

Feeling of having a lump in the throat ○ Yes ○ A Little ○ No

Swelling of the throat and neck area (not cold / allergy) ○ Yes ○ A Little ○ No

Clogged nose, running eyes, etc. (hay fever similar symptoms) ○ Yes ○ A Little ○ No

Dry nose	○ Yes ○ A Little ○ No
Problems with muscles and joints	○ Yes ○ A Little ○ No
muscle weakness	○ Yes ○ A Little ○ No
Muscle shakes	○ Yes ○ A Little ○ No
muscle cramps	○ Yes ○ A Little ○ No
Pain in the muscles	○ Yes ○ A Little ○ No
Pain in the big joints	○ Yes ○ A Little ○ No
Pain in the small joints	○ Yes ○ A Little ○ No
Joint swelling	○ Yes ○ A Little ○ No
Inflexibility in the joints in the mornings	○ Yes ○ A Little ○ No
Pain, tension in the neck or shoulder areas	○ Yes ○ A Little ○ No
Back pain	○ Yes ○ A Little ○ No
Problems with nerves and sensory organs	○ Yes ○ A Little ○ No
Paralysis	○ Yes ○ A Little ○ No
Dizziness in the arms and legs	○ Yes ○ A Little ○ No
Knitting, "darkening", burning	○ Yes ○ A Little ○ No
Headache, migrane	○ Yes ○ A Little ○ No
Clenching Eyes	○ Yes ○ A Little ○ No
Tearing	○ Yes ○ A Little ○ No
Dry eyes	○ Yes ○ A Little ○ No
Blurred vision	○ Yes ○ A Little ○ No
Red eyes or burning eyes	○ Yes ○ A Little ○ No
Increased sensitivity to touch	○ Yes ○ A Little ○ No
Improved temperature sensitivity	○ Yes ○ A Little ○ No

Reduced temperature sensitivity ○ Yes ○ A Little ○ No

Incoordination ○ Yes ○ A Little ○ No

Tinnitus or ringing in the ears ○ Yes ○ A Little ○ No

Feeling of pressure in the ears ○ Yes ○ A Little ○ No

Change of smell impression ○ Yes ○ A Little ○ No

Problem with the taste ○ Yes ○ A Little ○ No

Other problems with the nervous system? Please write below.

Dry skin ○ Yes ○ A Little ○ No

Oily skin ○ Yes ○ A Little ○ No

Hypersensitive skin ○ Yes ○ A Little ○ No

Pigment changes in the skin ○ Yes ○ A Little ○ No

Bruises ○ Yes ○ A Little ○ No

Itching ○ Yes ○ A Little ○ No

Acne ○ Yes ○ A Little ○ No

Skin, Nail or Foot Sponge ○ Yes ○ A Little ○ No

Disorder of wound healing (poor healing wound) ○ Yes ○ A Little ○ No

Other skin disorders? Please write below.

Problems with hair and nails ○ Yes ○ A Little ○ No

Hair loss on the head ○ Yes ○ A Little ○ No

Hair loss of smaller body hair ○ Yes ○ A Little ○ No

Loss of eyelashes, eyebrows, hair under the arms ○ Yes ○ A Little ○ No

Greasy hair ○ Yes ○ A Little ○ No

Increased body hair ○ Yes ○ A Little ○ No

Increased hair growth (head and face) ○ Yes ○ A Little ○ No

Cracked nails ○ Yes ○ A Little ○ No

Nails with stains longitudinal / transverse groove, holes ○ Yes ○ A Little ○ No

Problems with the gastrointestinal tract ○ Yes ○ A Little ○ No

Mouth wounds ○ Yes ○ A Little ○ No

Dry mouth ○ Yes ○ A Little ○ No

Bad breath ○ Yes ○ A Little ○ No

Changes with the gum ○ Yes ○ A Little ○ No

Drooling ○ Yes ○ A Little ○ No

Burning tongue ○ Yes ○ A Little ○ No

Problems with swallowing ○ Yes ○ A Little ○ No

Increased thirst ○ Yes ○ A Little ○ No

Rare, heartburn ○ Yes ○ A Little ○ No

Intolerance with fatty foods ○ Yes ○ A Little ○ No

Alcohol intolerance ○ Yes ○ A Little ○ No

Nausea ○ Yes ○ A Little ○ No

Bloating ○ Yes ○ A Little ○ No

Flatulence ○ Yes ○ A Little ○ No

Problems with the upper part of the stomach ○ Yes ○ A Little ○ No

Stomach cramps ○ Yes ○ A Little ○ No

Constipation ○ Yes ○ A Little ○ No

Diarrhea ○ Yes ○ A Little ○ No

Pain after itching ○ Yes ○ A Little ○ No

Other indigestional problems. Please write below.

How often do you go to the toilet?

o Once a day o Once a week o Once a month

OTHER AFFLICTIONS

Have you recently felt depressed be because of...?

Relationship problems (romantic relationships) ○ Yes○ No

Problems with the relationship with your children? ○ Yes○ No

Problems with parents / in-laws ○ Yes○ No

Serious diseases ○ Yes○ No

Death of a relative or partner ○ Yes○ No

Have you been exposed to emotional stress lately? Please enter below.

Death ○ Yes○ No

Problems at work ○ Yes○ No

Unemployment ○ Yes○ No

Bullying ○ Yes○ No

Are your symptoms a result of your environment? ○ Yes○ No

Are you disturbed by a certain environment ○ Yes○ No

Are the symptoms a result of a trip / vacation? ○ Yes○ No

Are the symptoms a result of the home environment? ○ Yes○ No

When will symptoms return (if they have been cured / relieved)? Please enter

Information about hobby and sport. Please write below.

PHARMACEUTICALS AND COST COMPENSATION

If you are taking / used any medication and / or cost compensation, please enter the name, reason, and how long you took it.

NUTRITIONAL HABITS

How often do you eat and drink the following?

Meat (pig, beef, lamb, bird, game)
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Egg
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Shellfish and crustaceans
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Bread, buns (1 slice or bun)
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

White bread
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times dailyy

Rye or diced bread
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Sausage, ham (slice)
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Butter
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Margarine
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Lard, other animal fats
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Vegetables (cooked or raw)
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Salad
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Fresh fruit / fruit
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Chocolate, marmalade
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Cakes and pastries
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Prepared or preserved meals
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Fast food
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Restaurant food
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Vinegar
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Mayonnaise
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Ready food
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Oats, cereals, etc.
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Noodles and other pasta
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Potatoes
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Rice
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Milk
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Cocoa
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Yoghurt
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Hard cheese
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Cream cheese
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Cottage cheese, fresh cheese
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Cream, crème fraiche
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Soy milk
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Apple
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Banana
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Orange, Mandarin, Grapefruit, Lemon
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Pome fruits
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Grapes
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Strawberries
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Other berries
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Pineapple, mango, kiwi, melon, other tropical fruits
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Nuts
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Tea
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Fruit juices
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Lemon juice
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Coca-Cola or the like
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Beer
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times dailyaily

Wine, sparkling wine
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

Other alcoholic beverages
○ 1 time a week ○ 2 times a week
○ 2-3 times a week ○ 1 time daily
○ 2-3 times daily ○ More than 4 times daily

OTHER INFORMATION

Any other relevant information that you want to share? Please write below.