



Dr Anna Forbes
INTEGRATIVE DOCTOR

Thank you for your interest in the **Biochemical Individualism Programme** (BodyTyping).

Please complete the enclosed questionnaire to help us identify your biochemical type so I can develop an enzyme protocol and nutrition plan for you to achieve a healthy balance.

It is very important that you take the time to fill out the forms completely. If necessary, you may also include additional information you feel is pertinent on the last page of the questionnaire or on a separate sheet of paper.

When you have completed the questionnaire, please email it back to me prior to the consultation, or print it out and bring it with you to the appointment.

Thank you and looking forward to working with you.

Dr. Anna Forbes

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BIOCHEMICAL INDIVIDUALISM QUESTIONNAIRE

Name _____

Address _____

Town / City _____ County _____ Postcode _____

Phone (Day) _____ (Evening) _____ E-mail _____

How did you hear about us? _____

Height _____ Weight _____ Date of Birth _____

Male Female What do you consider to be your ideal weight? _____

Any recent changes in weight? _____

What are your major nutritional / health goals? _____

Are you a Vegetarian? Yes No If yes, for how long? _____

Do you consider your lifestyle stressful? _____

Do you now or have you ever consumed alcohol regularly? Yes No Have done

If yes, how many drinks per week? _____

Have you ever used tobacco? Yes No Numbers of years _____ Amount per day _____ Quit

Are you now or were you ever regularly exposed to secondhand smoke? Yes No

If yes, when? _____

Have you ever used recreational drugs? Yes No

If yes, please specify: _____

Have you had plastic surgery / implantation of any kind (breast, cheek, etc)? Yes No

If yes, what? _____

Do you typically eat...? Breakfast Lunch dinner

If not, please explain: _____

This information is provided for nutritional purposes only. The information I am seeking is of an educational and nutritional nature and not a medical diagnosis. It is considered confidential information, and any results received will be documented for research and development reasons only.

Signature _____ Date _____

Attn: Dr. Anna Forbes

LIFESTYLE

How well have things been going for you lately?

	<i>Great</i>	<i>Good</i>	<i>Could be better</i>	<i>Not very good</i>	<i>Does Not Apply</i>
School	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Close friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Boy/girlfriend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP

What is your usual bedtime? _____

Wake time? _____

How well do you sleep? (check all that apply)

- Adequate (sleep through the night)
- Wake up feeling well rested
- Trouble falling asleep
- Wake up still tired
- Trouble staying asleep

How many times do you wake during the night?

Check off typical bedtime activities:

- Watch television
- Read a book
- Listen to music
- Bedtime snack
- Meditate
- Bathe/shower
- Drink alcohol
- Drink caffeinated beverage
- Other (specify) _____

Do you ever need to take a sleep aid?

- No Yes

Which ones, and at what dose?

How often: _____

EXERCISE

Do you exercise regularly now?

- No
 Yes

Have you in the past?

- No
 Yes

- Once per week
- 2 times per week
- 3 times per week
- 4 times per week or more

Amount per session:

- less than 15 minutes
- 15-30 minutes
- 30-45 minutes
- more than 45 minutes
- Other: _____

What type of exercises do you do currently?

- Jogging
- Walking (dog walking does not count)
- Weight training
- Water sports
- Aerobics
- Yoga
- Other: _____

DIGESTIVE HEALTH

Please mark in the chart below with information about recent bowel movements:

<p>Frequency:</p> <p><input type="checkbox"/> More than 3 times a day</p> <p><input type="checkbox"/> 2-3 times a day</p> <p><input type="checkbox"/> One time per day</p> <p><input type="checkbox"/> 4-6 times a week</p> <p><input type="checkbox"/> 2-3 times a week</p> <p><input type="checkbox"/> Once or fewer a week</p> <p>Consistency:</p> <p><input type="checkbox"/> Soft and well formed</p> <p><input type="checkbox"/> Often float</p> <p><input type="checkbox"/> Difficult to pass</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Thin, long or narrow</p> <p><input type="checkbox"/> Small and hard</p> <p><input type="checkbox"/> Loose, but not watery</p> <p><input type="checkbox"/> Alternating between hard and loose/watery</p> <p>Color:</p> <p><input type="checkbox"/> Dark brown</p> <p><input type="checkbox"/> Medium brown</p> <p><input type="checkbox"/> Very dark or black</p> <p><input type="checkbox"/> Greenish</p> <p><input type="checkbox"/> Blood is visible</p> <p><input type="checkbox"/> Varies a lot</p> <p><input type="checkbox"/> Yellow, light brown</p> <p><input type="checkbox"/> Greasy, shiny appearance</p>	<p>Do you experience intestinal gas? <i>(check all that apply)</i></p> <p><input type="checkbox"/> Present with pain</p> <p><input type="checkbox"/> Foul smell</p> <p><input type="checkbox"/> Little odour</p> <p><input type="checkbox"/> Excessive daily</p> <p><input type="checkbox"/> Occasionally</p> <p>Do you experience anal itching?</p> <p><input type="checkbox"/> Frequently</p> <p><input type="checkbox"/> Occasionally</p> <p><input type="checkbox"/> Rarely</p> <p><input type="checkbox"/> Never</p> <p>Do you experience any heartburn, chest pressure, or stomach pain?</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes</p> <p style="margin-left: 20px;">If yes, do you take anything for relief?</p>
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How many times a week do you eat out? _____

Are you the primary cook for the household? Yes No - If not, who is? _____

On a scale of 1-5, rate what extent you enjoy preparing/cooking food (1 = alot, 5 = hate it!) _____

Where do you do the bulk of your grocery shopping? _____

What percentage of your food intake is Organic? _____

Do you drink water? No Yes If yes, is it: Tap water Bottled water Mineral water

Approximately how many bottles or ounces per day? _____

DIET SECTION

Please select the foods that YOU ARE NOW or HAVE BEEN in the past drawn to:

PARA

- Snacks / Crackers / Chips
- Sweets / Candy
- Coffee / Tea
- Bread
- Cakes / Pies / Desserts
- Toast / Jam
- Pasta
- Potatoes
- Rice
- Fruit
- Honey
- Vegetarian meals

ESTR

- Rich or Heavily seasoned
- Foods Spicy Foods
- Fried Foods
- Mexican or Chinese Foods Pizza
- French Fries Creamy Dips
- Sauces / Gravies / Toppings
- Whipped Cream
- Ice Cream Butter
- Chocolate

SUPRA

- Alcohol
- Chicken
- Pork Chops / Ham / Bacon
- Steak / Hamburger Seafood
- Hot Dogs / Salami Pickles
- Olives Garlic
- Nuts / Peanuts Eggs
- Salt / Salty Foods

NEURO

- Dairy Products
- Milk
- Cheese (hard / cream)
- Ice Cream
- Yogurt
- Frozen Yogurt
- Cottage Cheese
- Fruit
- Cereal
- Whipped Cream
- Routine Meals
- Sweets

What foods do you like that cause digestive problems (gas, rash, allergies, belching)?

Pretend you have no health concerns and can have any meal or food. What would it be?

PAST HISTORY

Please tick any of the following problems which YOU HAVE NOW or HAVE EXPERIENCED in the past:

PARA

<input type="checkbox"/> PMS	<input type="checkbox"/> Mood Swings
<input type="checkbox"/> Cold hands/ feet	<input type="checkbox"/> Neck / Shoulder aches
<input type="checkbox"/> Depression	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Eczema	<input type="checkbox"/> Skin eruptions
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sprue/Wheat intolerance
<input type="checkbox"/> Brain Fog	<input type="checkbox"/> Thyroid
<input type="checkbox"/> Headaches	<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Hypoglycemia	

ESTRO

<input type="checkbox"/> Aching feet	<input type="checkbox"/> Hepatitis/Jaundice
<input type="checkbox"/> Arthritis	<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Gallbladder problems
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Hysterectomy
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Breast lumps/tumors
<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Menstrual problems
<input type="checkbox"/> Cystitis	<input type="checkbox"/> Urinary problems
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Prostate problems

SUPRA

<input type="checkbox"/> Alcohol addiction	<input type="checkbox"/> Arteriosclerosis
<input type="checkbox"/> Sciatica	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Back problems	<input type="checkbox"/> Gingivitis/Bleeding gums
<input type="checkbox"/> Belching	<input type="checkbox"/> Kidney Disease (stones)
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Cardiovascular disease
<input type="checkbox"/> Gout	<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Heartburn/indigestion
<input type="checkbox"/> Ear infections	

NEURO

<input type="checkbox"/> Aching knees	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Frequent Infections
<input type="checkbox"/> Hives	<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Colds	<input type="checkbox"/> Milk intolerance
<input type="checkbox"/> Colitis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Weak Constitution	
<input type="checkbox"/> Chronic Allergies (seasonal/food)	
<input type="checkbox"/> Chemical/Environmental Sensitivity	

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abscesses Allergies | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/ AIDS | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Lupus Malaria | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fungal Infections | <input type="checkbox"/> Measles | <input type="checkbox"/> Polio |
| (type: _____) | <input type="checkbox"/> Goiter | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Candidiasis | <input type="checkbox"/> Gonorrhoea | <input type="checkbox"/> Mumps | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nervous Breakdown | <input type="checkbox"/> Sinus Infection |
| <input type="checkbox"/> Chronic Viral Infections | <input type="checkbox"/> Haemorrhoids | <input type="checkbox"/> Neuralgia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hiatal Hernia | | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diarrhoea | | | |

Other health concerns not listed: _____

REMEMBER: Disease is not bound to happen...it can be overcome!

PERSONALITY

Check the personality questions that best describe you.

Choose the group of statements that best describe you in general:

 PARA

- Outgoing and extroverted
- Sometimes scattered and forgetful
- A people person

 ESTRO

- Nurturing and caring Organized
- Concerned for other people

 SUPRA

- Stubborn and/or hardheaded
- Not concerned with details, more concerned with the “big picture”
- Enjoy being in control or in charge

 NEURO

- Introverted and very analytical
- Detail oriented, especially in making decisions
- Creative

Choose the group of traits that best describe your eating habits:

 PARA

- I enjoy eating / it is entertaining I sometimes forget to eat

 ESTRO

- I like to eat for comfort
- I don't like to eat in the mornings

 SUPRA

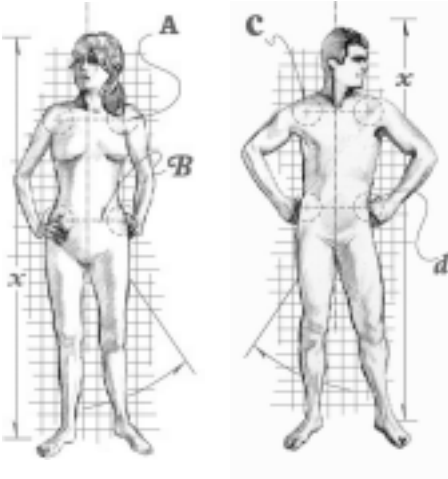
- I will sometimes go all day without eating and eat a large dinner
- My meal is not complete without meat

 NEURO

- I like to eat a little bit of food throughout the day
- I get sick if I eat too much

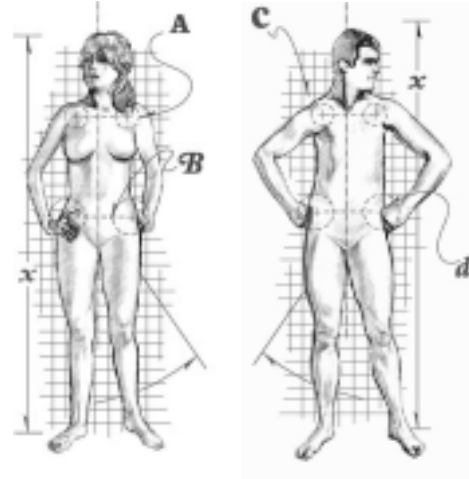
WHICH ONE BEST DESCRIBES YOUR BODY?

PARA



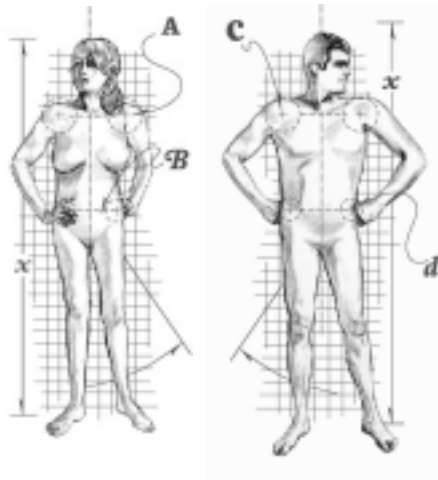
- ◇ Carries weight evenly, but can be held in the waist / stomach
- ◇ Buttocks are high and round
- ◇ Width of clavicle and hips is equal

ESTRO/ TESTRO



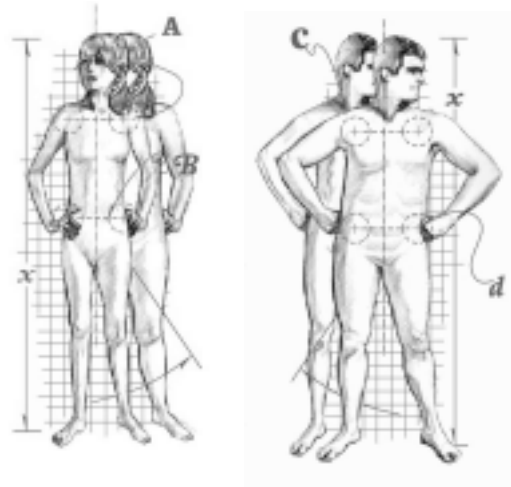
- ◇ Carries weight in the hips and thighs
- ◇ Buttocks are low and flat
- ◇ Width of clavicle is narrower than distance between the hip points

- ◇ Carry weight in upper body, especially the stomach
- ◇ No buttocks
- ◇ Width of clavicle is wider than distance between the hip points



SUPRA

- ◇ Carry weight fairly evenly and body is soft
- ◇ Remained similar since teens
- ◇ No real distinction between width of clavicle, waist, and hip points



NEURO