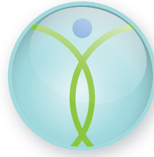


Dr Anna Forbes
INTEGRATIVE DOCTOR

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

Dr Anna Forbes
The Hale Clinic, 4 Harley Street, London, W1G 9PB
enquiries@drannaforbes.com
www.drannaforbes.com

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

Name______________________________

LIFESTYLE

How well have things been going for you lately?

	Great	*Good*	*Could be better*	*Not very good*	*Does Not Apply*
School	☐	☐	☐	☐	☐
Job	☐	☐	☐	☐	☐
Social life	☐	☐	☐	☐	☐
Close friends	☐	☐	☐	☐	☐
Sex	☐	☐	☐	☐	☐
Your attitude	☐	☐	☐	☐	☐
Boy/girlfriend	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐
Parents	☐	☐	☐	☐	☐
Spouse	☐	☐	☐	☐	☐

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: ______________________________

Name______________________________

MEDICATIONS / SUPPLEMENTS

What medications are you taking now? (Please also include non-prescription drugs you take daily/regularly)

Medication Name	Purpose	Dosage	Start Date

Do you take any other over the counter medications on an **occasional basis**? ☐ Yes ☐ No
If yes, which one(s)?____

____

How many times have you taken antibiotics as an infant or child?
☐ Less than 5 times ☐ More than 5 times ☐ More than 10 times ☐ So many times I lost count

Reason: ____

____

As an adult, how often do you take antibiotics?
☐ Never ☐ Once a year (on average) ☐ 1-3 times a year (on average) ☐ Longer (explain)

Reason: ____

____

Were you ever on antibiotics for a prolonged period of time? ☐ Yes ☐ No

If yes, explain:____

____

____

Have you ever / how often have you taken oral steroids? (e.g., Cortisone, Prednisone, etc.)

	Less than 5 times	*Greater than 5 times*	*Greater than 10 times*
☐ Infancy/Childhood	☐	☐	☐
☐ Teen	☐	☐	☐
☐ Adulthood	☐	☐	☐

Name______________________________

What vitamins, minerals, and other nutritional supplements you are currently taking? Indicate unit (mg or IU) and form (for example: calcium carbonate vs. calcium lactate)

Type of Supplement	Brand	How Many and When?	Start Date

Name____________________________

DIGESTIVE HEALTH

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

Frequency:
- ☐ More than 3 times a day
- ☐ 2-3 times a day
- ☐ One time per day
- ☐ 4-6 times a week
- ☐ 2-3 times a week
- ☐ Once or fewer a week

Consistency:
- ☐ Soft and well formed
- ☐ Often float
- ☐ Difficult to pass
- ☐ Diarrhea
- ☐ Thin, long or narrow
- ☐ Small and hard
- ☐ Loose, but not watery
- ☐ Alternating between hard and loose/watery

Color:
- ☐ Dark brown
- ☐ Medium brown
- ☐ Very dark or black
- ☐ Greenish
- ☐ Blood is visible
- ☐ Varies a lot
- ☐ Yellow, light brown
- ☐ Greasy, shiny appearance

Do you experience intestinal gas?
(check all that apply)
- ☐ Present with pain
- ☐ Foul smell
- ☐ Little odour
- ☐ Excessive daily
- ☐ Occasionally

Do you experience anal itching?
- ☐ Frequently
- ☐ Occasionally
- ☐ Rarely
- ☐ Never

Do you experience any heartburn, chest pressure, or stomach pain?
- ☐ No
- ☐ Yes

If yes, do you take anything for relief?

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? ____________________

Name ______________________________

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?

Name ______________________________

PAST HISTORY

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

PARA

- ☐ PMS
- ☐ Cold hands/ feet
- ☐ Depression
- ☐ Eczema
- ☐ Fatigue
- ☐ Brain Fog
- ☐ Headaches
- ☐ Hypoglycemia
- ☐ Mood Swings
- ☐ Neck / Shoulder aches
- ☐ Pancreatitis
- ☐ Skin eruptions
- ☐ Sprue/Wheat intolerance
- ☐ Thyroid
- ☐ Low Blood Pressure

ESTRO

- ☐ Aching feet
- ☐ Arthritis
- ☐ Diabetes
- ☐ Cirrhosis
- ☐ Cataracts
- ☐ Psoriasis
- ☐ Cystitis
- ☐ Hay Fever
- ☐ Hepatitis/Jaundice
- ☐ High Cholesterol
- ☐ Gallbladder problems
- ☐ Hysterectomy
- ☐ Breast lumps/tumors
- ☐ Menstrual problems
- ☐ Urinary problems
- ☐ Prostate problems

SUPRA

- ☐ Alcohol addiction
- ☐ Sciatica
- ☐ Back problems
- ☐ Belching
- ☐ Fatigue
- ☐ Gout
- ☐ Loss of hearing
- ☐ Ear infections
- ☐ Arteriosclerosis
- ☐ High Blood Pressure
- ☐ Gingivitis/Bleeding gums
- ☐ Kidney Disease (stones)
- ☐ Cardiovascular disease
- ☐ Acid Reflux
- ☐ Heartburn/indigestion

NEURO

- ☐ Aching knees
- ☐ Diverticulosis
- ☐ Hives
- ☐ Colds
- ☐ Colitis
- ☐ Weak Constitution
- ☐ Chronic Allergies (seasonal/food)
- ☐ Chemical/Environmental Sensitivity
- ☐ Crohn's Disease
- ☐ Frequent Infections
- ☐ Irritable Bowel
- ☐ Milk intolerance
- ☐ Asthma

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

Other health concerns not listed:____

____
____
____
____
____

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

Name ______________________________

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

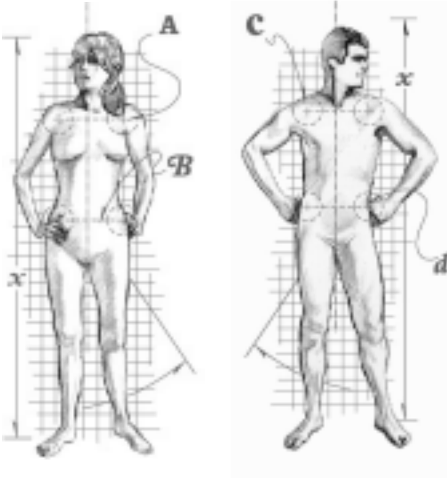
☐ *NEURO*

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

Name ______________________________

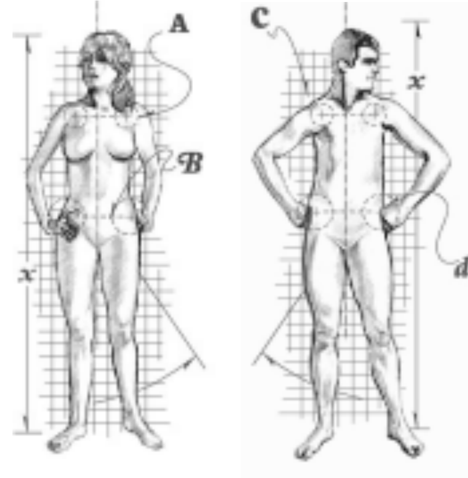
WHICH ONE BEST DESCRIBES YOUR BODY?

☐ PARA



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

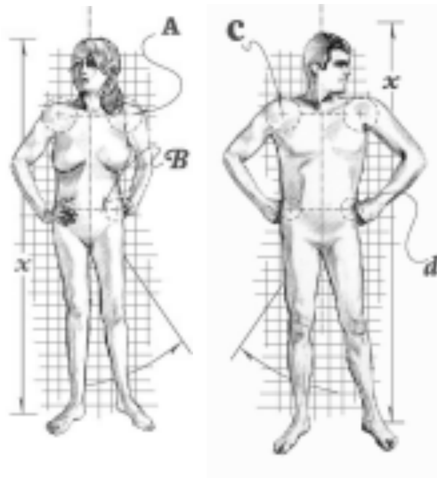
☐ ESTRO/ TESTRO



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

☐ SUPRA

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



☐ NEURO

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