

IS HE/SHE IN REGULAR CONTACT WITH:

Please tick box

Algaecides (copper containing)	<input type="checkbox"/>	Gas boiler	<input type="checkbox"/>
Aluminium Kettle	<input type="checkbox"/>	Garden Sprays	<input type="checkbox"/>
Aluminium pans	<input type="checkbox"/>	Herbicides – weedkiller	<input type="checkbox"/>
Antacids	<input type="checkbox"/>	Mercury amalgam fillings	<input type="checkbox"/>
Ascot – type of water heater	<input type="checkbox"/>	Microwave oven	<input type="checkbox"/>
Cigarette smoke	<input type="checkbox"/>	Mobile phone or mast	<input type="checkbox"/>
Electric over-blanket	<input type="checkbox"/>	Paint stripper	<input type="checkbox"/>
Fire retardant	<input type="checkbox"/>	PC/VDU	<input type="checkbox"/>
Flea collars (on pets)	<input type="checkbox"/>	Pesticides	<input type="checkbox"/>
Flea drops (in pet's fur)	<input type="checkbox"/>	PVC Clingfilm	<input type="checkbox"/>
Fly sprays	<input type="checkbox"/>	Refined flour/sugar	<input type="checkbox"/>
Fluoridated water	<input type="checkbox"/>	Tinned food/drinks	<input type="checkbox"/>
Fluoride toothpaste	<input type="checkbox"/>	Tuna fish	<input type="checkbox"/>
Foil wrap	<input type="checkbox"/>	Wallpaper remover	<input type="checkbox"/>
Food additives	<input type="checkbox"/>	Woodworm treatment	<input type="checkbox"/>

Are your water pipes:

Is your water tank:

Copper	<input type="checkbox"/>	Copper	<input type="checkbox"/>
Lead	<input type="checkbox"/>	Fibreglass	<input type="checkbox"/>
Plastic	<input type="checkbox"/>	Plastic	<input type="checkbox"/>
Glass	<input type="checkbox"/>	Steel	<input type="checkbox"/>
Comments:			

Please return your completed form and hair sample(s) to:

**3 Lower Queens Road, Clevedon, N Somerset BS21 6LX
Tel. 01275 878953 e: info@foresight-preconception.org.uk**

Registered Charity No. 279160



**FORESIGHT
CHILD
QUESTIONNAIRE**

Date: _____ Ref No. _____ (to be inserted by Foresight)

All information in this document will be treated in strictest confidence.

Parent's Name:.....

Child's Name:.....

Address:.....
.....

Email:

Tel. No(s):.....

Child's Age: DOB: Male/Female:.....

Ethnic origin:..... Hair Colour:.....

Height (m):..... Weight (kg):

Foresight Practitioner details (if applicable):

Name:

Address:

Email:

(Please specify if results should be emailed to practitioner)

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SPECIFIC INFORMATION FOR HAIR SAMPLE

Brand name of Shampoo & Conditioner:

INFANCY

Birth weight: Apgar:

Malformation(s) *please give details*.....

Problems during pregnancy?.....

Problems at birth?.....

Breastfeeding?.....

Allergic illness, colic & health problems in babyhood?.....

Reaction to vaccination/immunization?.....

Milestones (development).....

CHILDHOOD

Chronic illness/conditions?.....

Has he/she been frequently treated for middle ear, throat or eye infections?.....

Frequent or regular medication?.....

Has he/she had urine test for infection?.....

Has he/she had stool test for parasites?.....

School performance?.....

MEDICAL HISTORY:

Does he/she suffer from any of the following Deficiency Symptoms?

Please tick box if so:

Acne	<input type="checkbox"/>	Frequency (urine)	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	Griping	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Grooved tongue	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	Halitosis	<input type="checkbox"/>
Apathy	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
Back Pain	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Bedwetting	<input type="checkbox"/>	Irritability	<input type="checkbox"/>
Bleeding gums	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>
Body odour	<input type="checkbox"/>	Lank hair/bald patches	<input type="checkbox"/>
Bowel cramps	<input type="checkbox"/>	Learning difficulties	<input type="checkbox"/>
Brittle nails/bitten nails	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>
Bruising	<input type="checkbox"/>	M. Encephalopathy (M.E.)	<input type="checkbox"/>
Catarrh	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Coeliac disease	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	Obesity	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>
Cold hands/feet	<input type="checkbox"/>	Palour (paleness)	<input type="checkbox"/>
Cramping	<input type="checkbox"/>	Panic attacks	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>
Deafness/glue ear	<input type="checkbox"/>	Sensitivity to light	<input type="checkbox"/>
Dental decay	<input type="checkbox"/>	Sensitivity to noise	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Short sight/astigmatism	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	Stretch marks (rapid growth)	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	Sweating (heavy)	<input type="checkbox"/>
Dizziness/vertigo	<input type="checkbox"/>	Threadworms	<input type="checkbox"/>
Dyslexia	<input type="checkbox"/>	Toxoplasmosis	<input type="checkbox"/>
Ear infections	<input type="checkbox"/>	Under weight	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	Urinary Tract infections	<input type="checkbox"/>
Excessive crying	<input type="checkbox"/>	Urticaria (hives)	<input type="checkbox"/>
Excessive thirst	<input type="checkbox"/>	White spots on nails	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>		<input type="checkbox"/>