Health Questionnaire

General Details

Name_____

Address_____

Phone_____Email_____

DOB_____Age_____Sex: Male/Female

I understand that the information I provide in this health questionnaire will be used to assess my suitability to participate in The ACPHARM Biome Protocol. I understand that the assessment is not used to diagnose or treat any medical conditions. I agree to see my usual doctor for assessment of any symptoms I may have.

I acknowledge that the information provided below is current and complete. I take full responsibility for any complications arising from withholding information or from my participation in The ACPHARM Biome Protocol.

Signature_____Date:_____

Health Conditions

Please list any current medical conditions and how they are being treated:

Medical Condition	Current Treatment

Do you have any of the following (tick Y or N):

Condition	Yes	No	Please specify condition
Heart disease			
Kidney disease			
Liver disease or hepatitis			
HIV or TB			
Anorexia or bulimia			
Vitamin toxicity			
Cancer			
Currently undergoing chemo or radiotherapy			
Pregnant or breast feeding			
Severe allergies			
A history of anaphylaxis			
Type 1 Diabetes			

Height (cm)	Current Weight (kg)	Goal Weight (kg)

Systems Review:

Please tick the number which best describes the frequency or severity of any symptoms you have experienced over the previous month, from 0-3 using the key below.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently/Daily

Gut Health	0	1	2	3
Bloating, fullness or indigestion after a meal				
Constipation				
Abdominal cramps or aches				
Excessive gas				
Diarrhoea or frequent bowel movements				
Total				

Immune Health	0	1	2	3
Frequent infections				
Recurrent rashes or itching				
Nasal congestion or discharge				
Joint pain, stiffness or swelling				
Worsening symptoms with certain foods				
Total				

Metabolic Health	0	1	2	3
Fatigue, sluggishness				
Feeling cold				
Gaining weight				
Fluid retention				
Loss of hair				
Total				

Hormone Health	0	1	2	3
Shaky or irritable between meals				
Waking hungry at night				
Cravings for sugar, coffee or chocolate				
Low mood, stressed or mood swings				
Fatigue easily				
Total				

Brain Health	0	1	2	3
Difficulty concentrating or focusing on tasks				
Poor memory				
Cravings for food, alcohol or drugs				
Insomnia or waking at night				
Feeling overwhelmed by small things				
Total				

Please total each section, you should have a total score between 0 and 15

The ACPHARM Biome Protocol Consent Form

I _____ have requested participation in The Biome Protocol for the purpose of assisting with weight loss.

I understand that:

- I will be required to adhere to a strict diet and supplementation plan for a period of 6 weeks, followed by a maintenance plan to ensure long-term results.
- Results will vary and there are no guarantees.
- I must continue any treatments or medications prescribed by my usual doctor.
- I must discontinue all non-prescription vitamins and supplements, unless approved by my practitioner.
- The Biome Protocol may cause the following side effects:
    - Common: fatigue, dizziness, cravings, brain fog, headache.
    - Uncommon: diarrhoea, constipation, low blood pressure, nausea and reflux.
    - Rare: vitamin toxicity, allergic reaction, symptoms include generalized itch or rash, facial swelling, difficulty breathing and difficulty swallowing. If I experience any of these symptoms, I will call "000" Emergency for assistance.
- I must see my usual practitioner for any pre-existing medical conditions, to follow up pathology results or for any conditions that may arise during my participation in The Biome Protocol.
- My personal information collected during the course of the program will be made available to relevant members of the treating team and Australian Custom Pharmaceuticals for the purpose of my management.
- The Biome Protocol has not been approved by TGA for weight loss or management of my symptoms or medical concerns.
- There are TGA-approved prescription treatments for weight loss that I can discuss with my doctor.
- I do not expect my practitioner to foresee all possible side effects and should a side effect occur, I understand that further treatment or medication may be required. In this instance, I take financial responsibility for any costs incurred.

I confirm that:

- I agree to receive information, via telecommunication, related to my participation in this program (e.g. results of blood tests) and if needed, have consultations via telephone.
- I am not pregnant or breast-feeding
- I do not suffer from or ever had any of the following:
    - Severe allergies or anaphylaxis
    - Chronic liver, heart or kidney disease
    - Anorexia or bulimia
    - TB or HIV
    - Current cancer, chemo or radiotherapy
    - Vitamin toxicity
- I agree I have been given sufficient information and written material. I have read the above statements and fully understand the risks associated with The Biome Protocol. I have had opportunity to discuss my concerns and alternative options with a staff member. I acknowledge that the information provided is correct and complete. I take full responsibility for any complications arising from withholding information that has been requested.
- I consent to the transfer of my personal information using email, fax or other electronic methods between relevant staff involved in my management.

Signature_____Date:_____

Full Name_____