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**Foundation Assessment: Environmental and Nutritional**

**Please complete the following assessment and return to clinic either by post or electronic format/scanned into an e mail. It is a rather long form but all these details are very relevant in order for us to pinpoint what environmental issues may be factors to consider in your current health picture.**

**Date \_\_\_\_\_\_\_\_\_ Surname \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Post code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Telephone: Work\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E amil address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**D.O.B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Status (Married, Single, Divorced, Widowed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of GP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Address of GP Practice \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Height\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. NUTRITION/DIET/FLUID INTAKE**

How much do you eat/drink of the following (indicated by a tick) and please give an example of what you would eat on an average day in the Food diary on page 2.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **None** | **Very little** | **Moderate** | **Very much** |
| Red meat i.e., beef, venison, lamb, pork etc |  |  |  |  |
| Fish |  |  |  |  |
| Chicken |  |  |  |  |
| Eggs |  |  |  |  |
| Milk (cows) |  |  |  |  |
| Cheese (cows) |  |  |  |  |
| Yoghurt (cows) |  |  |  |  |
| Butter |  |  |  |  |
| Olive oil |  |  |  |  |
| Refined margarine products |  |  |  |  |
| Refined sugary foods |  |  |  |  |
| Pure Fruit juices |  |  |  |  |
| Vegetables |  |  |  |  |
| Fruit |  |  |  |  |
| Fizzy drinks |  |  |  |  |
| Salty foods |  |  |  |  |
| Coffee |  |  |  |  |
| Black tea |  |  |  |  |
| Herbal tea |  |  |  |  |
| Wheat products, esp. bread, biscuits etc |  |  |  |  |
| Oats |  |  |  |  |
| Barley |  |  |  |  |
| Rye |  |  |  |  |
| Soya products |  |  |  |  |

**Food Diary**

Breakfast

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner/tea

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snacks

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What % of your diet would you say is organic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you eat food cooked in a microwave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Liquid intake**

Indicate the type of water you generally drink by applying a tick in the appropriate box:

|  |  |  |
| --- | --- | --- |
| Tap water | Spring water in bottles | Distilled water |
| Filtered water | Well water | Other |

How many glasses of water do you drink in a day on average? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you drink bottled water what brand do you like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And is it in plastic or glass bottles? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alcohol: On average, how many units do you drink per week (1 unit = 1 standard glass of wine)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. EXERCISE**

**Sport/activity (may include gardening, taking a walk with a baby buggy) that you routinely take part in:**

|  |  |
| --- | --- |
| Sport/Activity | How often per week |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

How do you feel after exercise? Please tick.

Energised

More tired

**3a. SLEEP ENVIRONMENT**

Do you watch TV in your bedroom or use your mobile phone or other screens directly before bed and if so for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your bedroom have a pleasant “cool” feeling for sleeping? Yes \_\_\_ No \_\_\_

Do you have any external lights e.g. streetlights coming through your window at bedtime?

Yes \_\_\_ No \_\_\_

Do you do shift work? Yes\_\_\_ No\_\_\_\_

**3b.SLEEP (Other than environmental factors)**

What time do you generally go to bed and get up? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you generally sleep through the night? Yes \_\_\_ No\_\_\_

Do you have insomnia (i.e. getting off to sleep?) Yes \_\_\_ No \_\_\_

Do you wake up in the night? If so at what times generally?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you waken in the night, do you struggle to get back to sleep again? Yes \_\_\_ No \_\_\_

Are you waking up due to night time urination? Yes\_\_\_ No \_\_\_

Do you wake up in the morning feeling refreshed? Yes\_\_\_ No\_\_\_

Are you very thirsty on waking? Yes\_\_\_ No \_\_\_

Are you aware that you snore? Yes \_\_\_ No \_\_\_

Do you have sleep apnoea? Yes \_\_\_ No \_\_\_

Do you generally breathe through your nose or mouth or both? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does pain keep you awake or prevent you from getting off to sleep? Yes\_\_\_ No \_\_\_

What is your main sleeping position? Please tick

On your back / on your right side / on your left side / on your front / a blend of all of these.

Do you experience any tinnitus (ringing, buzzing, whooshing in your ears) Yes\_\_\_\_ No \_\_\_\_

If so does it prevent you from getting to sleep Yes\_\_\_\_ No\_\_\_\_

**4.COGNITIVE FUNCTION**

**Do you have any of the following issues: please tick.**

* You forget things more often.
* You forget important events such as appointments or social engagements.
* You lose your train of thought or the thread of conversations, books, or movies.
* You feel increasingly overwhelmed by making decisions, planning steps to accomplish a task, or understanding instructions.
* You start to have trouble finding your way around familiar environments.
* You become more impulsive or show increasingly poor judgment.
* Your family and friends notice any of these changes.

**5. TOXIC ELEMENTS 1 (Heavy metals in vaccinations, amalgam fillings (silvery grey), gold fillings).**

How many amalgam fillings (the grey ones) do you currently have? \_\_\_\_\_

How many gold fillings do you have? \_\_\_\_\_\_

How many amalgam fillings did you have in the past but have been replaced with white composites and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What safety procedures were used (i.e a rubber dam used in the mouth, oxygen pipe in your nose, metal detox removal supplement after the dental session)?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To your knowledge would your mother be likely to have had amalgam fillings before your birth or whilst she was pregnant with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did your mother have any amalgam fillings removed whilst she was pregnant with you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been exposed to amalgam vapour i.e. as a dentist or dental technician?

Yes \_\_\_ No \_\_\_

**Vaccination history. Please indicate which of the following vaccinations you have received.**

|  |  |  |
| --- | --- | --- |
| **Vaccine** | **Date given (approx.)** | **Any side effects felt after the vaccine** |
| **Hep A** |  |  |
| **Hep B** |  |  |
| **Hep C** |  |  |
| **Hep D** |  |  |
| **MMR** |  |  |
| **Chicken pox** |  |  |
| **Polio** |  |  |
| **Flu** |  |  |
| **DPT** |  |  |
| **Tetanus** |  |  |
| **Smallpox** |  |  |
| **Covid 19 initial vaccines**  **Covid 19 Boosters** |  |  |
| **Other** |  |  |

**6. TOXIC ELEMENTS 2 (Dentistry-Other)**

How many of the following to your knowledge have you currently got? Please tick.

Cavitations \_\_\_

Root canal fillings \_\_\_

Dentures \_\_\_

Crowns \_\_\_

Gum tattoos \_\_\_

Bridges \_\_\_

Implants \_\_\_

Other \_\_\_

**7. TOXIC ELEMENTS 3 (mould/candida/fungus) Please tick.**

|  |  |  |
| --- | --- | --- |
|  | Past | Present |
| Mould in your workplace |  |  |
| Mould at your home |  |  |
| Water damage in your house |  |  |

**8. TOXIC ELEMENTS 4 (Harmful frequencies i.e. EMF/Radiation/Electro pollutants/X rays/MRI scans etc)**

Do you have a computer, laptop, I pad, TV, mobile phone or other EMF emitting device? Please circle.

Do you have any of these switched on in your bedroom before you go to sleep? Please circle.

Computer / laptop / I pad / TV / mobile phone or other EMF emitting device.

Are any of these electrical appliances directly near your bed e.g., a clock radio, lamp, mobile phone, fuse box, router, laptop, computer, game console? Please circle.

Is your regular mobile phone usage low, moderate or high? Please circle.

Is your regular phone corded or cordless? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use any of the following? Please circle

Electric blanket / Electric shaver / Electric toothbrush

If you use a computer / laptop, how many hours per day? \_\_\_\_\_\_

Do you have broadband or Wi-Fi? Please circle.

If you have Wi-fi, do you turn it off each time you have used it? \_\_\_

If you watch TV, how many hours on average per day? \_\_\_\_\_

In your house where is the fuse box? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have SMART meters on any of your Utilities i.e., Gas, Electric or Water? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If so for how long have they been installed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many x rays have you had in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many mammograms have you had in your life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any of the following scans and how many?

\_\_Ultrasound

\_\_MRI

\_\_CT/CAT

\_\_Other

Do you live near or used to live near any of the following? Please circle:

Pylons / a cellular tower / high power generator / crematorium / industrial zone / polluting factory / nuclear plant

**9. TOXIC ELEMENTS 5 (harmful exposures to e.g. smoke, chemicals)**

Have you ever been exposed to the following in the past or currently? Please tick

|  |  |  |
| --- | --- | --- |
| **Toxin** | **Past** | **Present** |
| Cigarette smoke (by smoking yourself) |  |  |
| Smoke inhalation from a fire |  |  |
| Cigarette smoke (passively) |  |  |
| Coal fire smoke |  |  |
| Recreational drugs |  |  |
| Weed killers (herbicides, pesticides, anti- plant mould sprays) |  |  |
| Paints (not Eco friendly) |  |  |
| Heavy metal exposures e.g.welder, mechanic, jewellery maker |  |  |
| Printing inks |  |  |
| Tattoos |  |  |
| Body products that have toxic ingredients e.g. shampoos, body creams, body spray deodorants. |  |  |
| Anti-flea sprays for animals (local pest control for whole house infestations) |  |  |
| OTHER Please state |  |  |

**10.TOXIC ELEMENTS 6 (Body implants)**

Have you any body implants?

|  |  |  |
| --- | --- | --- |
| **Implant** | **Past** | **Present** |
| Breast |  |  |
| Hip |  |  |
| Knee |  |  |
| Other (please state) |  |  |

Please note any other relevant information for this assessment:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Thank you for taking the time to complete this assessment sheet. It will be invaluable in   
working out what areas you may need extra help with before moving on to the medical Assessment. Please return to the clinic address below,**

PLEASE NOTE: The information you provide on this assessment is confidential and will not be passed on to any third party without the consent of you the patient. It will not be stored on any device that would allow access to it via the internet. This is in accordance with current Data Protection legislation.

Clinic contact details: please ask for full address once you are booked in for a consult.

**Clinic of Natural Medicine**, **Claughton On Brock, Nr Preston, Lancs.**

**Tel 01995 605446**

[www.clinicofnaturalmedicine.uk](http://www.clinicofnaturalmedicine.uk)

[info@clinicofnaturalmedicine.uk](mailto:info@clinicofnaturalmedicine.uk)