Nutritional Therapy Questionnaire

Please provide details as fully and accurately as possible. If at any time you need more space please continue on a separate sheet.

Title	First Name	Last Name	DOB	Age
Address				

Post Code	Email	Contact Numbers	Occupation	Work Environment

Health Profile

What is your main reason for seeking nutritional advice?

What outcome are you hoping to achieve?

Please list the issues you would like to focus on. Continue on a separate sheet if you need more space.

Health issue (e.g. arthritis, overweight)	Management so far (e.g. GP, operation, exercise, paracetamol etc.)	Onset/duration

Have you had any recent health tests? Please specify or attach reports if appropriate

Have you had any other major surgery biopsies diagnosed medical conditions significant periods of ill health or do you suffer from any allergies chronic or niggling health problems? (please give details e.g. high blood pressure frequent colds recurrent urinary infections etc.)

Do you suspect your symptoms relate to a particular event or time in your life?

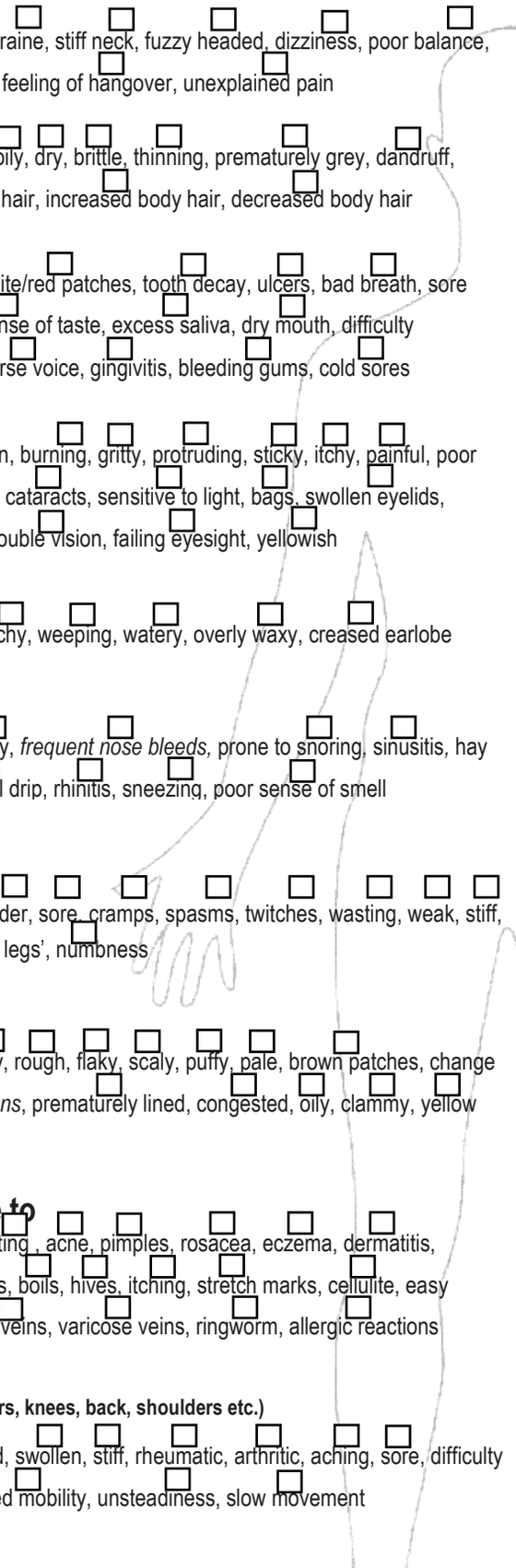
Medication & Remedies

Please list **anything you take regularly** including GP prescribed medication, self-prescribed medication (e.g. painkillers) nutritional supplements, herbal or homeopathic remedies. Continue on a separate sheet if necessary.

Remedy	Dose	Condition being treated	Frequency & Duration

Antibiotic history: please state when and why you last took antibiotics plus any previous times you can remember:

Body Scan - Please select any conditions that you regularly experience by either ticking the relevant boxes, highlighting or underlining.



Head

headaches, migraine, stiff neck, fuzzy headed, dizziness, poor balance, pounding head, feeling of hangover, unexplained pain

Hair

poor condition, oily, dry, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decreased body hair

Mouth

sore tongue, white/red patches, tooth decay, ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, difficulty *swallowing,* hoarse voice, gingivitis, bleeding gums, cold sores

Eyes

prone to infection, burning, gritty, protruding, sticky, itchy, painful, poor night vision, dry, cataracts, sensitive to light, bags, swollen eyelids, *blurred vision,* double vision, failing eyesight, yellowish

Ears

blocked, sore, itchy, weeping, watery, overly waxy, creased earlobe

Nose

congested, runny, *frequent nose bleeds,* prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

Muscles

loss of tone, tender, sore, cramps, spasms, twitches, wasting, weak, stiff, frozen, 'restless legs', numbness

Skin

Slow to heal, dry, rough, flaky, scaly, puffy, pale, brown patches, change in moles *or lesions*, prematurely lined, congested, oily, clammy, yellow

Skin prone to

excessive sweating , acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions

Joints **(fingers, knees, back, shoulders etc.)**

painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

Mood - *(please indicate your predominant states - even if they conflict)*

Depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, irritated, annoyed, overwhelmed, *suicidal,* fluctuating, aggressive

Mind

forgetful, difficulty learning new things, easily confused, can't switch off, difficult concentrating, easily frustrated, easily distracted, difficult to make decisions, loss of interest in daily life, fogginess, dyslexia, dyspraxia, insomnia, hyperactive, panic attacks, no motivation

Chest

frequent colds and chest infections, asthma, bronchitis, palpitations, heart condition, *chest discomfort/pain, short of breath,* difficulty breathing, wheezy, *persistent cough,* noisy breathing, breast pain

Gut

bloated, painful tender, cramping, distended, nausea, hiatus hernia, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, vomiting, irritable bowel, coeliac, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, *constipation, diarrhoea*

Genitals

itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, *painful or frequent urination*, unexplained discharge

Hands

dry, cracked, eczema, sore joints, puffy, cold, chilblains, *numbness,* tingling, feel clumsy & uncoordinated, poor circulation

Nails

fragile, dry, brittle, flaky, peeling, split, fungal, hangnails, infected, split cuticles, ridged, spoon shaped, white spots on more than 2, horizontal white lines, thickened or 'horny', dark nails, pale nail bed

Legs & Feet

restless legs, swollen, aching, athlete's foot, burning feet, tender heels, gout, sciatica, cold feet, tingling, *numb*, prickling.

Important Symptoms: **Please indicate if you suffer from any of the following symptoms which may require additional medical care:**

persistent or unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine, stools; breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash or weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy

Your vital statistics

	What is your normal blood pressure
	your resting pulse rate?
	your current weight?
	your height?
	your waist circumference? (if known)
	your hip circumference? (if known)
A	your blood type? (if known)
Stabl	Is your weight stable, increasing or decreasing?
No	Did you have the recommended immunisations as a child?

Your family history

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc.) State disease, age at onset, gender.

Grandparents:
Parents:
Siblings:
Children:

Your daily life

No	Do you enjoy your daily life?
	How many people depend on your support?
No	Do you feel supported by people around you?
No	Are you recently separated/divorced/a new parent?
No	Are you recently bereaved?
No	Have you moved house or changed jobs recently?
No	Do you work long or irregular hours?
No	Is your workload bigger than you can manage?
No	Are you under significant stress in any other way?
No	Do you feel guilty when you are relaxing?
No	Do you have a strong drive for achievement?
No	Do you often do 2 or 3 tasks simultaneously?
No	Do you take regular exercise?
No	Do you sleep well?
No	Is your job active?
No	Do you have any active hobbies?
	What do you do for relaxation?

Your digestion

Do you regularly experience…

No	Indigestion (after food or between meals?)
No	Bowel movement shortly after eating?
No	Indigestion after fatty food?
No	Frequent stomach upsets or stomach pain?
No	Nausea or vomiting?
No	Pain between the shoulders or under the ribs?
No	Constipation or hard-to-pass stools?
No	Diarrhoea or 'urgency to go'?
Yes	Undigested food in stools?
No	Blood or mucus in stools?
No	Generally inconsistent bowel movements?
No	Anal itching?
No	Thrush or cystitis?
Onc	How often do you have a bowel movement?
No	Have you noticed any recent change in bowel habit?
Pal	Are your stools pale, mid brown, dark brown, black, grey?
No	Have you ever had a stomach upset after foreign travel?
No	Do any foods cause digestive problems? (which ones?)

Your toxic exposure

No	Do you live, exercise or work in a city or by a busy road?
No	Do you spend a lot of time on busy roads?
No	Do you live close to an agricultural area?
No	Do you drink unfiltered water?
No	Do you drink alcohol? If so, how many units a week?
	What is your normal alcoholic drink?
No	Do you smoke? If so, how many a day?
No	Do you live in a smoky atmosphere?
No	Do you think you may be addicted to anything?
No	Do you spend a lot of time in front of a TV or VDU?
No	Do you spend a lot of time on a mobile phone?
No	Do you sunbathe a lot?
No	Are you a frequent flyer?
No	Are you exposed to chemicals through work or hobby?
No	Do you heat, freeze or wrap food in plastics?
No	Do you cook or wrap food in aluminium?
No	Do you regularly take antacid (indigestion) medication?
10%	Roughly what percentage of your food is organic?
No	Do you frequently fry or roast food at high temperatures?
No	Do you regularly eat browned or barbecued foods?
No	Do you eat oily fish or shellfish more than 3 x a week?
No	Do you regularly consume artificial sweeteners?
No	Do you floss your teeth regularly?
No	Are your teeth filled with mercury amalgams?

Your energy levels

No	Do you need more than 8 hours sleep per night
No	Is your energy less than you want it to be?
No	Do you find it difficult to get going in the morning?
No	Do you feel drowsy during the day?
Mor	What time(s) of day is your energy lowest?
No	Do you get dizzy or irritable if you don't eat often?
No	Do you use caffeine, sugar or nicotine to keep going?
No	Do you find it difficult to concentrate?
No	Do you feel dizzy or light-headed if you stand up quickly?
No	Do you suffer from unexplained fatigue or listlessness?

Women Only

No	Are you pregnant? If so, how many weeks? _____
No	Are you breast-feeding at present?
0	How many children have you had?
No	Have you ever had a miscarriage?
No	Have you had problems with fertility?
No	What contraception do you use?
No	***Are you still menstruating?***
No	Are you or have you been on HRT?
No	Are your periods regular?
No	Any bleeding or spotting in between?
No	***Are your periods particularly heavy*** or painful?
No	Do you suffer from PCOS, fibroids, endometriosis?
No	Any known genito-urinary conditions?
No	Are you happy with your sex drive?

Menstruating Women: please check a box if you experience: pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches. Other?

Menopausal Women: please check a box if you suffer from: hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

Men Only

No	Do you experience mood swings or depression?
No	Loss of sex drive?
No	Loss of motivation and drive?
No	Any known genito-urinary conditions?
No	Fertility problems?
No	Problems achieving or maintaining an erection?
No	Frequent or difficult urination?
No	Prostate problems - Wake at night to urinate
No	Difficult to start or stop urine stream
No	Pain or burning when urinating

Eating Habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find hard to give up?

No	Do you cater for a special diet in the household?
Me	Who does the cooking in your household?
No	Do you avoid any food for cultural/ethical reasons?
No	Are you allergic to any foods?
No	Do you suspect any foods don't agree with you?
No	Have you recently changed your diet?
No	Do you eat on the move/when stressed?
No	Do you ever have eating binges?
	What do you binge on?
No	Have you ever suffered from an eating disorder?
No	Do you chew your food thoroughly?
No	Are you excessively thirsty?

Please complete the separate food and lifestyle diary

Your Health Carers

Is this your first visit to a Nutritional Therapist? Y

How did you find out about me?

GP's Name & Address

Are any other therapists/clinics involved in your care? Please list:

I have disclosed all the relevant information applicable to this consultation and my health status at this point in time. I consent for the information provided to be used by my Nutritional Therapist and for my therapist to liaise with appropriate health professionals.

Signed : Date:

3 Day Diet Diary

Name____ **Date**_______

Please choose 2 fairly typical week days and a weekend or 'day off' and record as much as you can about your eating, sleep and leisure patterns on the page below. Please give as much information as possible - home cooked or not, brand names, fresh, packaged, whole, refined, organic etc. to help your nutritional therapist to build an accurate picture of your lifestyle.

Your Diet - please record your food intake across 2 work or week days and 1 weekend/day off.

	Day One	Day Two	Day Three
Breakfast	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snacks	Times:	Times:	Times:
Drinks	— coffees (___sugars/cup) — 'normal' tea (___sugars per cup) — green/herbal tea — fizzy drinks/cordial — units of alcohol — glasses of water other drinks......	— coffees (___sugars/cup) — 'normal' tea (___sugars per cup) — green/herbal tea — fizzy drinks/cordial — units of alcohol — glasses of water other drinks......	— coffees (___sugars/cup) — 'normal' tea (___sugars per cup) — green/herbal tea — fizzy drinks/cordial — units of alcohol — glasses of water other drinks......

Your Routine - please do the same for your routine

	Day1	Day 2	Day off
Wake up time			
Get up time			
Work day start time			
Work day breaks (total hrs)			
Work day end time			
Time spent travelling			
Time spent exercising			
Type of exercise			
Exercise time of day			
Time spent relaxing			
Type of relaxation			
Other leisure activity			
Other routine...			
Time spent outdoors			
Energy low times			
Overall mood			
Go to bed time			
Fall asleep time			
Uninterrupted sleep?	No	No	No