**Nutritional Therapy Questionnaire**



Please complete this form as fully and accurately as possible. If you need more space please use a separate sheet

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title |  | First Name |  | Last Name |  | Date of Birth |  | Age |  |

|  |  |
| --- | --- |
| Address |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Post Code |  | E-mail |  | Phone Numbers |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Occupation |  | Work environment (e.g. city farm) |  |

**Health Profile**

|  |  |
| --- | --- |
| What is your main reason for seeking nutritional advice? |  |
| WWhat outcome are you hoping to achieve? |  |

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

|  |  |  |  |
| --- | --- | --- | --- |
| Health Problem (e.g. arthritis) | Management so far (e.g. GP, operation, exercise, paracetamol etc.) | Onset (date) | Duration |
| 1  |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |
| 5 |  |  |  |

|  |
| --- |
| Have you had any recent health tests? Please specify or attach, if appropriate. If you have had blood tests a copy of the results would be helpful |
|  |
|  |

|  |
| --- |
| Have you had any other major surgery, biopsies, diagnosed medical conditions, significant periods of ill health or do you suffer from any 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? |
|  |

**Do you have a medically identified food allergy or intolerance? YES / NO** If you do please provide details

|  |
| --- |
|  |

**Medication & Remedies**

Please list **anything you take regularly** including GP prescribed medication, over the counter 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 UNDERLINE or HIGHLIGHT any conditions that you regularly experience (ignore italics)

**Head**

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

**Hair**

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

**Mouth**

sore tongue, tooth decay, mouth ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, poor sense of taste, excess saliva, dry mouth, difficult swallowing, hoarse voice, gingivitis, bleeding gums, cold sores

**Eyes**

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

**Ears**

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

**Nose**

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

**Muscles**

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

**Skin**

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

**Skin prone to**

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

**Joints** (fi**ngers, knees, back, shoulders etc.)**

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

**Mood** (please underline 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, annoyed, overwhelmed, *suicidal*, fluctuating, aggressive

**Mind**

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

**Chest**

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

**Gut**

bloated, tender, cramping, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, *painful*, irritable bowel syndrome, coeliac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, 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, splitting, hangnails (split cuticles), ridged, spoon shaped, white spots on more than 2 nails, horizontal white lines, thickened or ‘horny, dark nails, pale nail bed, infected

**Legs & Feet**

restless legs, swollen, aching, athlete’s foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, numb, prickling.

**Important Symptoms:**

**Please indicate by underlining 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

**Health Care Providers**

|  |  |  |  |
| --- | --- | --- | --- |
| Is this your first visit to a Nutritional Therapist? |  | How did you find out about me? |  |

|  |  |  |  |
| --- | --- | --- | --- |
| GP’s Name |  | Address |  |
| Phone |  |  |  |

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

**Your family history**

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

|  |  |
| --- | --- |
| Grandparents |  |
| Parents |  |
| Siblings |  |
| Children |  |

**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)? |  |
| your blood type (if known)? |  |
| Is your weight stable, increasing or decreasing? |  |
| Did you have the normal immunisations as a child? |  |

**Your daily life**

|  |  |
| --- | --- |
| Do you enjoy your daily life? |  |
| How many people depend on your support? |  |
| Do you feel supported by people around you? |  |
| Are you recently separated/divorced/a new parent? |  |
| Are you recently bereaved? |  |
| Have you moved house or changed jobs recently? |  |
| Do you work long or irregular hours? |  |
| Is your workload bigger than you can manage? |  |
| Are you under significant stress in any other way? |  |
| Do you feel guilty when you are relaxing? |  |
| Do you have a strong drive for achievement? |  |
| Do you often do 2 or 3 tasks simultaneously? |  |
| Do you take regular exercise? |  |
| Is your job active? |  |
| Do you have any active hobbies? |  |
| Do you sleep well? |  |
| What do you do for relaxation? |  |

**Your energy levels**

|  |  |
| --- | --- |
| Do you need more than 8 hours sleep per night? |  |
| Is your energy less than you want it to be? |  |
| Do you find it difficult to get going in the morning? |  |
| Do you feel drowsy during the day? |  |
| What time(s) of day is your energy lowest |  |
| Do you get dizzy or irritable if you don’t eat often? |  |
| Do you use caffeine, sugar or nicotine to keep going? |  |
| Do you find it difficult to concentrate? |  |
| DoDo you feel dizzy or light-headed if you stand up quickly? |  |
| Do you suffer from unexplained fatigue or listlessness? |  |

**Your digestion**

Do you regularly experience…

|  |  |
| --- | --- |
| Indigestion (after food or between meals)? |  |
| Indigestion after fatty food? |  |
| Bowel movement shortly after eating? |  |
| Frequent stomach upsets or stomach pain? |  |
| Nausea or vomiting? |  |
| Pain between the shoulders or under the ribs? |  |
| Constipation or hard-to-pass stools? |  |
| Diarrhoea or ‘urgency to go’? |  |
| Blood or mucus in stools? |  |
| Undigested food in stools? |  |
| Generally inconsistent bowel movements? |  |
| Anal itching? |  |
| Thrush or cystitis? |  |
| How many bowel movements do you have in 24 hours? |  |
| Have you noticed any recent change in bowel habit? |  |
| Are your stools pale, mid brown, dark brown, black, grey? |  |
| Have you ever had a stomach upset after foreign travel? |  |
| Do any foods cause digestive problems? (which ones?) |  |

**Your toxic exposure**

|  |  |
| --- | --- |
| Do you live, exercise or work in a city or by a busy road? |  |
| Do you spend a lot of time on busy roads? |  |
| Do you live close to an agricultural area? |  |
| Do you drink unfiltered water? |  |
| Do you live in a smoky atmosphere? |  |
| Do you think you may be addicted to anything? |  |
| Do you spend a lot of time in front of a TV or VDU? |  |
| Do you spend a lot of time on a mobile phone? |  |
| Do you sunbathe a lot? |  |
| Are you a frequent flyer? |  |
| Are you exposed to chemicals through work or hobby? |  |
| Do you heat, freeze or wrap food in plastics? |  |
| Do you cook or wrap food in aluminium? |  |
| Do you regularly take antacid (indigestion) medication? |  |
| Roughly what percentage of your food is organic? | % |
| Do you frequently fry or roast food at high temperatures? |  |
| Do you regularly eat browned or barbecued foods? |  |
| Do you regularly consume artificial sweeteners? |  |
| Do you floss your teeth regularly? |  |
| Are your teeth filled with mercury amalgams? |  |

**Women Only Men Only**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Are you pregnant? If so, how many weeks? |  |  | Do you experience mood swings or depression? |  |
| Are you trying to become pregnant? |  |  | Loss of sex drive? |  |
| Are you breast-feeding at present? |  |  | Loss of motivation and drive? |  |
| How many children have you had? |  |  | Any known genito-urinary conditions? |  |
| Have you had problems with fertility? |  |  | Fertility problems? |  |
| Have you ever had a miscarriage? |  |  | Problems achieving or maintaining an erection? |  |
| What contraception do you use? |  |  | Frequent or difficult urination? |  |
| ***Are you still menstruating?*** |  |  | Prostate problems? |  |
| Are you or have you been on HRT? |  |  | Wake at night to urinate?  |  |
| Are your periods regular? |  |  | Difficult to start or stop urine stream? |  |
| Any bleeding or spotting in between? |  |  | Pain or burning when urinating? |  |
| ***Are your periods particularly heavy*** or painful? |  |
| Do you suffer from PCOS, fibroids, endometriosis?  |  |
| Any known genito-urinary conditions? |  |
| Are you happy with your sex drive? |  |

**Menstruating** **Women**: please underline if you experience:

pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches. Other?

**Menopausal Women:** please underline if you suffer from:

hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

**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? |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you cater for a special diet in the household? |  |  | Have you ever suffered from an eating disorder? |  |
| Who does the cooking in your household? |  |  | Do you ever have eating binges? |  |
| Do you avoid any food for cultural/ethical reasons? If yes, what do you avoid? |  |  | What do you binge on? |  |
| Do you suspect any foods don’t agree with you? |  |  | Do you chew your food thoroughly? |  |
| Do you eat out frequently? |  |  | Are you excessively thirsty? |  |
| Enjoy eating and preparing food? |  |  |  |  |

How many of the following do you consume in an average **day?** (a portion is approximately a handful)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Number of biscuits? |  |  | Portions of vegetables? |  |
| Number of cakes? |  |  | Portions of fruit? |  |
| Cups of coffee? |  |  | Glasses of water? |  |
| Cups of tea? |  |  | Slices of bread? |  |

How many of the following do you consume in an average **week?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Units of alcohol? |  |  | Eggs? |  |
| Portions of red meat?\* |  |  | Portions of processed meat?\*\* |  |
| Number of ready meals? |  |  | Portions of oily fish?\*\*\* |  |
| Portions of poultry? |  |  | Portions of broccoli & cabbage? |  |

\* Red meat = pork, beef, lamb \*\* Processed meat = sausages, ham, ready made burgers, packet meats

\*\*\* Oily fish = salmon, fresh tuna, herring, mackerel, anchovies, sardines, pilchards

*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 |  |

***Please complete the separate food and lifestyle diary***

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** |  | **Date** |  |

**3 Day Lifestyle Diary**

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 me build an accurate picture of your lifestyle

|  |  |  |  |
| --- | --- | --- | --- |
|  | Weekday 1 | Weekday 2 | Day off |
| Breakfast | Time | Time | Time |
| Lunch | Time | Time | Time |
| Dinner | Time | Time | Time |
| Snacks | Time | Time | Time |
| Drinks | Coffee |  | Coffee |  | Coffee |  |
|  | No of sugars per coffee |  | No of sugars per coffee |  | No of sugars per coffee |  |
|  | “Normal” tea |  | “Normal” tea |  | “Normal” tea |  |
|  | No of sugars per tea |  | No of sugars per tea |  | No of sugars per tea |  |
|  | Green /herbal tea |  | Green /herbal tea |  | Green /herbal tea |  |
|  | Fizzy drinks/cordial |  | Fizzy drinks/cordial |  | Fizzy drinks/cordial |  |
|  | Units of alcohol |  | Units of alcohol |  | Units of alcohol |  |
|  | Glasses of water |  | Glasses of water |  | Glasses of water |  |
|  | Other drinks |  | Other drinks |  | Other drinks |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | Day 1 | 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… |  |  |  |
| Energy low times |  |  |  |
| Overall mood |  |  |  |
| Go to bed time |  |  |  |
| Fall asleep time |  |  |  |
| Uninterrupted sleep? | Y/N | Y/N | Y/N |