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 _____

What 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? _____
Do 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

Are you pregnant? If so, how many weeks? _____
Are you trying to become pregnant? _____
Are you breast-feeding at present? _____
How many children have you had? _____
Have you had problems with fertility? _____
Have you ever had a miscarriage? _____
What contraception do you use? _____
Are you still menstruating? _____
Are you or have you been on HRT? _____
Are your periods regular? _____
Any bleeding or spotting in between? _____
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? _____

Men Only

Do you experience mood swings or depression? _____
Loss of sex drive? _____
Loss of motivation and drive? _____
Any known genito-urinary conditions? _____
Fertility problems? _____
Problems achieving or maintaining an erection? _____
Frequent or difficult urination? _____
Prostate problems? _____
Wake at night to urinate? _____
Difficult to start or stop urine stream? _____
Pain or burning when urinating? _____

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? _____
Who does the cooking in your household? _____
Do you avoid any food for cultural/ethical reasons? If yes, what do you avoid? _____
Do you suspect any foods don't agree with you? _____
Do you eat out frequently? _____
Enjoy eating and preparing food? _____

Have you ever suffered from an eating disorder? _____
Do you ever have eating binges? _____
What do you binge on? _____
Do you chew your food thoroughly? _____
Are you excessively thirsty? _____

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

Number of biscuits? _____
Number of cakes? _____
Cups of coffee? _____
Cups of tea? _____

Portions of vegetables? _____
Portions of fruit? _____
Glasses of water? _____
Slices of bread? _____

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

Units of alcohol? _____
Portions of red meat?* _____
Number of ready meals? _____
Portions of poultry? _____

Eggs? _____
Portions of processed meat?** _____
Portions of oily fish?*** _____
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

3 Day Lifestyle 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 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