Vitality Nutrition
Supporting Health and Wellbeing

VITALITY NUTRITION HEALTH QUESTIONAIRE

Section 1 – Personal Details

First Name:_________________________ Last Name:__________________________________

Date of Birth: _______________________ Age: _______________________________________

Sex: Male/Female Marital status:________________________________

Address:
____

____
_

Postcode: __________________________

Telephone

Home ______________________Work_____________________Mobile_________________________

Email: _____________________________

How would you prefer to be contacted? Email/Phone/ Mail

Occupation: _________________________ Do you work night shifts? Yes/No

GP's Name: __________________________ Surgery Name:________________________________

Surgery Address:

____
__

____
__

Surgery Telephone Number: ______________________

Do you give permission for you GP to be contacted?   Yes/No

Section 2 - Current Health and Medical History

Please list the health concerns you would like to address – State the duration of each and start with the condition which is your priority

Have you seen your doctor/GP regarding any health condition?   Yes/No

Are you currently seeing any other health professionals/therapists regarding any health condition?

Please list

Has anything helped any of these conditions?

Does anything make any of these conditions worse?

____

Please list all prescription and over the counter medications you take on a regular basis:

Name	Dosage	How often?	For how long?	Any side effects

Please list all supplements you are currently taking:

Name/Brand	Dosage	How often?	For how long?	Any side effects

Height: ______________________________ Weight: ______________________________

What is the most and the least you have ever weighed?

Most=________________________________ Least=____

Blood Pressure: ________________________

Resting Pulse: __________________________

Have you had any recent health tests? If yes, please list with results if appropriate:

____

____

____

Please list approximate hospitalisation dates and reason for hospitalisation

Details of any childhood or past serious illnesses

Any known allergies?

____

Section 3 - Family Health

Who do you currently live with?

____

Do you have any children? Yes/No

If yes, please state age and sex:

____

Please state any major illnesses of within your family

Father	
Mother	
Father's mother	
Father's father	
Mother's mother	
Mother's father	
Sibling:	
Other:	

Section 4 - Lifestyle Profile

Do you currently exercise? Yes/No

What type of exercise/sport do you do?

____

How many times per week (total)? 1 2 3 4 5+ How long per session? <15 15-30 30-45 45-60 60+

How long have you been doing this level of exercise?

____

At what time do you usually go to bed? ______

At what time do you usually get up in the morning? _______   Do you wake refreshed?   Yes/ No

Do you wake in the night ?   Yes/No   What time? _____________   Reason?_____________

What do you do for relaxation?

____

Do you have any hobbies or favourite pastimes?

____

Have you ever smoked cigarettes/cigars ? Yes/No   At what age did you start smoking? ________________

How many cigarettes do you currently smoke each day?

____

If you have stopped smoking, at what age did you stop?

____

Do you drink alcohol? Yes/No   If so which type of drink_____________________

On how many days per week (approximately)? 1 2 3 4 5 6 7

How many glasses per day? _______   At what time of day? ________

Do you use recreational drugs? If so, which?

____

Thank you for completing this questionnaire. Please return it to julie@vitalitynutrition.uk at least 24hrs before your initial consultation,