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_____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 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
1		
2		
3		
4		
5		

Have you had any recent health tests? Please specify or attach, 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 clicking on the grey boxes

Head

headaches, 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, white/red patches, tooth decay, ulcers, bad breath, sore throats, 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

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

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, slow to heal

Skin prone to

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

Joints **(fingers, 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, 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, wheezing, *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 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

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 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

_____ 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 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 often do you have a bowel movement?
_____ 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 drink alcohol? If so, how many units a week?___
_____ What is your normal alcoholic drink?
_____ Do you smoke? If so, how many a day?_____
_____ 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 eat oily fish or shellfish more than 3 x a week?
_____ Do you regularly consume artificial sweeteners?
_____ Do you floss your teeth regularly?
_____ Are your teeth filled with mercury amalgams?

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?

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?

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

_____ 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

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?
_____ Are you allergic to any foods?
_____ Do you suspect any foods don't agree with you?
_____ Have you recently changed your diet?
_____ Do you eat on the move/when stressed?
_____ Do you ever have eating binges?
_____ What do you binge on?
_____ Have you ever suffered from an eating disorder?
_____ Do you chew your food thoroughly?
_____ Are you excessively thirsty?

Please complete the separate food and lifestyle diary

Your Health Carers

Is this your first visit to a Nutritional Therapist?

How did you find out about me?

What is your GP's Name?

Address

Phone

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 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 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.

	Weekday 1	Weekday 2	Day Off
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?	Select	Select	Select