Nutritional Health Questionnaire

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

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_____

_____

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? _____

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 UNDERLINE any conditions that you regularly experience and CIRCLE any that are a particular problem. (ignore italics)

Head

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

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, *difficult swallowing,* hoarse voice, gingivitis, bleeding gums, amalgams, 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

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, stiff, frozen, 'restless legs', numbness.

Skin

dry, rough, flaky, red, scaly, puffy, pale, brown patches, prematurely lined, spotty, pimples, congested, oily, clammy, coarse, yellow.

Skin prone to

acne, 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, annoyed, overwhelmed, 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, sharp pain, irritable bowel syndrome, coeliac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, *constipation, diarrhoea.*

Genitals

itchy skin, cystitis, thrush, painful, ulcers, warts, herpes, groin pain, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, prostatitis, excessive 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 toenails, burning feet, tender heels, gout, cold feet, tingling, *numbness*, prickling.

Important Symptoms:

Please indicate by underlining if you suffer from any of the following symptoms which *may* require additional medical care: unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, urine, stools; breast lumps, calf swelling, change in nature of moles, difficulty swallowing, excessive thirst, frequent urination, inability to gain weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash or weight loss.

Your vital statistics

_____ What is your normal blood pressure?
_____ What is your resting pulse rate?
_____ What is your blood type?
_____ What is your current weight?
_____ What is your height?
_____ What is your waist circumference?
_____ What is your hip circumference?
_____ Is your weight stable, increasing or decreasing?
_____ Did you have the normal immunizations 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?
_____ Have you moved house or changed jobs recently?
_____ Are you separated/divorced/a new parent?
_____ Are you recently bereaved?
_____ Are you under significant stress in any way?
_____ Do you work long or irregular hours?
_____ Is your workload bigger than you can manage?
_____ 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 many bowel movements do you have in 24 hours?
_____ Have you noticed any recent change in bowel habit?
_____ Is your stool colour pale, mid brown, dark brown, black, clay, grey?
_____ Have you ever had a stomach upset after travelling?
_____ Have you linked any foods to digestive problems? (which ones?)

Your environment

_____ 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 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?

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 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?
_____ Are you happy with your sex drive?

Menstruating Women: please indicate by underlining 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?

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 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

What are your favourite foods?

What foods do you dislike?

What foods do you crave?

What foods would you find hard to give up?

_____ Do you cater for a special diet in the family?
_____ Who does the cooking in your family?
_____ Do you avoid any food for cultural/ethical reasons?
_____ 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 included with this form.

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 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_____Dated_____

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, sleeping 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 3
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