



# Nutrition Programme Questionnaire

This questionnaire is designed to provide your nutritionist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Post Code: \_\_\_\_\_

Telephone Number: (Work) \_\_\_\_\_ (Home) \_\_\_\_\_

Occupation: \_\_\_\_\_ Age: \_\_\_\_\_

What is: Your Weight (without clothes): \_\_\_\_\_ stone \_\_\_\_\_ lbs

Your Height (without shoes): \_\_\_\_\_ feet \_\_\_\_\_ inches

## Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems eg: Headaches 5 years (Continue on a separate sheet if you need more space)

Health problem	Duration
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

What medications (drugs) do you take for these? State daily dosage. \_\_\_\_\_

Under what circumstances do these problems improve? \_\_\_\_\_

Under what circumstances do they get worse? \_\_\_\_\_

What other illnesses have you had in the past ten years? \_\_\_\_\_

What operations have you had? \_\_\_\_\_

What is your normal blood pressure? (don't worry if you don't know) \_\_\_\_\_

What is your resting pulse rate per minute? \_\_\_\_\_

(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

## Heredity Profile

Do you have any children? If so, state age and sex.

Are there any particular illnesses that they suffer from?

\_\_\_\_\_

\_\_\_\_\_

How many brothers and sisters do you have? State age

What illness is/was your father prone to?

and sex. \_\_\_\_\_

What illness is/was your mother prone to?  
\_\_\_\_\_  
\_\_\_\_\_

# SYMPTOM ANALYSIS

Each question in this section starts with a list of symptoms associated with nutritional deficiency. Underline the conditions you often suffer from. Some symptoms are repeated. Please underline them in all cases.

## **Mouth ulcers**

Poor night vision

Acne

## **Frequent colds or infections**

Dry flaky skin

Dandruff

Thrush or cystitis

Diarrhoea

## **Rheumatism or arthritis**

Back ache

Tooth decay

Hair loss

Excessive sweating

Muscle cramps, or spasms

## **Joint pain or stiffness**

Lack of energy

Lack of sex drive

## **Exhaustion after light exercise**

## **Easy bruising**

## **Slow wound healing**

Varicose veins

Loss of muscle tone

Infertility

## **Frequent colds**

Lack of energy

## **Frequent infections**

Bleeding or tender gums

Easy bruising

Nose bleeds

Slow wound healing

Red pimples on skin

Tender muscles

Eye pains

Irritability

Poor concentration

'Prickly' legs

Poor memory

Stomach pains

Constipation

Tingling hands

Rapid heart beat

## **Burning or gritty eyes**

## **Sensitivity to bright lights**

Sore tongue

Cataracts

Dull or oily hair

Eczema or dermatitis

Split nails

Cracked lips

Lack of energy

Diarrhoea

Insomnia

Headaches or migraines

Poor memory

Anxiety or tension

Depression

Irritability

Bleeding or tender gums

Acne

Muscle tremors or cramps

Apathy

Poor concentration

## **Burning feet or tender heels**

Nausea or vomiting

Lack of energy

Exhaustion after light exercise

Anxiety or tension

Teeth grinding

Infrequent dream recall

## **Water retention**

Tingling hands

Depression or nervousness

Irritability

Muscle tremors or cramps

## **Lack of energy**

Flaky skin

Poor hair condition

Eczema or dermatitis

Mouth over sensitive to hot or cold

Irritability

Anxiety or tension

## **Lack of energy**

Constipation

Tender or sore muscles

Pale skin

Eczema

Cracked lips

Prematurely greying hair

Anxiety or tension

Poor memory

## **Lack of energy**

Poor appetite

Stomach pains

Depression

## **Dry skin**

Poor hair condition

Prematurely greying hair

**Tender or sore muscles**

**Poor appetite or nausea**

**Eczema or dermatitis**

## **Dry, rough skin**

Dry eyes

Frequent infections

Poor memory

Loss of hair or dandruff

Excessive thirst

Poor wound healing

PMS or breast pain

Infertility

## **Muscle cramps or tremors**

## **Insomnia or nervousness**

## **Joint pain or arthritis**

## **Tooth decay**

## **High blood pressure**

## **Muscle tremors or spasms**

Muscle weakness

Insomnia or nervousness

High blood pressure

Irregular heart beat

Constipation

Fits or convulsions

Hyperactivity

Depression

## **Pale skin**

## **Sore tongue**

## **Fatigue or listlessness**

## **Loss of appetite or nausea**

## **Heavy periods or blood loss**

Poor sense of taste or smell

## **White marks on more than two finger nails**

Frequent infections

Stretch marks

Acne or greasy skin

Low fertility

Pale skin

Tendency to depression

Poor appetite

## **Muscle twitches**

## **Childhood 'growing pains'**

## **Dizziness or poor sense of balance**

## **Fits or convulsions**

## **Sore knees**

## **Family history of cancer**

## **Signs of premature ageing**

## **Cataracts**

## **High blood pressure**

## **Frequent infections**

## **Excessive or cold sweats**

## **Dizziness or irritability after 6 hours without food**

Need for frequent meals

Cold hands

Need for excessive sleep or drowsiness  
during the day

Excessive thirst

## **'Addicted' to sweet foods**

# LIFESTYLE ANALYSIS

## Cardiovascular Profile

- \_\_\_\_\_ Is your blood pressure above 140/90?
- \_\_\_\_\_ Is your pulse after 15 minutes rest above 75?
- \_\_\_\_\_ Are you more than 14lbs (7kg) over your ideal weight?
- \_\_\_\_\_ Do you smoke more than 5 cigarettes a day?
- \_\_\_\_\_ Do you do less than two hours exercise a week?
- \_\_\_\_\_ Do you eat more than one spoon of sugar a day?
- \_\_\_\_\_ Do you eat meat more than 5 times a week?
- \_\_\_\_\_ Do you usually add salt to your food?
- \_\_\_\_\_ Do you have more than 2 alcoholic drinks a day?
- \_\_\_\_\_ Is there a history of heart disease in your family?

## Exercise Profile

- \_\_\_\_\_ Do you take exercise that noticeably raises your heart beat for 20 minutes more than 3 times a week?
- \_\_\_\_\_ Does your job involve vigorous activity?
- \_\_\_\_\_ Do you regularly play a sport? (*football, squash, etc.*)
- \_\_\_\_\_ Do you have any physically tiring hobbies? (*gardening, etc.*)
- \_\_\_\_\_ Do you consider yourself fit?

## Pollution Risk Profile?

- \_\_\_\_\_ Do you live in a city or by a busy road?
- \_\_\_\_\_ Do you spend more than 2 hours a week in traffic?
- \_\_\_\_\_ Do you exercise (*jog, cycle, play sports*) by busy roads?
- \_\_\_\_\_ Do you smoke more than 5 cigarettes a day?
- \_\_\_\_\_ Do you live or work in a smoky atmosphere?
- \_\_\_\_\_ Do you buy foods exposed to exhaust fumes?
- \_\_\_\_\_ Do you generally eat non-organic produce?
- \_\_\_\_\_ Do you drink more than 1 unit or oz of alcohol a day? (*1 glass of wine, 1 pint of beer, or 1 measure of spirits*)
- \_\_\_\_\_ Do you spend a lot of time in front of a TV or VDU?
- \_\_\_\_\_ Do you usually drink unfiltered tap water?

## Stress Profile

- \_\_\_\_\_ Is your energy less now than it used to be?
- \_\_\_\_\_ Do you feel guilty when relaxing?
- \_\_\_\_\_ Do you have a persistent need for achievement?
- \_\_\_\_\_ Are you unclear about your goals in life?
- \_\_\_\_\_ Are you especially competitive?
- \_\_\_\_\_ Do you work harder than most people?
- \_\_\_\_\_ Do you easily become angry?
- \_\_\_\_\_ Do you often do 2 or 3 tasks simultaneously?
- \_\_\_\_\_ Do you get impatient if people or things hold you up?
- \_\_\_\_\_ Do you have difficulty getting to sleep?

## Glucose Tolerance Profile

- \_\_\_\_\_ Do you need more than 8 hours sleep a night?
- \_\_\_\_\_ Are you rarely wide awake within 20 minutes of rising?
- \_\_\_\_\_ Do you need something to get you going in the morning, like a tea, coffee or cigarette?
- \_\_\_\_\_ Do you have tea, coffee, sugar containing foods or drinks, or cigarettes, at regular intervals during the day?
- \_\_\_\_\_ Do you often feel drowsy during the day?
- \_\_\_\_\_ Do you get dizzy or irritable if you don't eat often?
- \_\_\_\_\_ Do you avoid exercise due to tiredness?
- \_\_\_\_\_ Do you sweat a lot or get excessively thirsty?
- \_\_\_\_\_ Do you sometimes lose concentration?
- \_\_\_\_\_ Is your energy less now than it used to be?

## Digestion Profile

- \_\_\_\_\_ Do you chew your food thoroughly?
- \_\_\_\_\_ Do you sometimes suffer from bad breath?
- \_\_\_\_\_ Are you prone to stomach upsets?
- \_\_\_\_\_ Do you often get a burning sensation in your stomach?
- \_\_\_\_\_ Do you find it difficult digesting fatty foods?
- \_\_\_\_\_ Do you occasionally use indigestion tablets?
- \_\_\_\_\_ Do you suffer from flatulence or bloating?
- \_\_\_\_\_ Do you experience anal irritation?
- \_\_\_\_\_ Do you have a bowel movement daily?
- \_\_\_\_\_ Do your stools float?

## Immune Profile

- \_\_\_\_\_ Do you get more than three colds a year?
- \_\_\_\_\_ Do you find it hard to shift an infection (*cold or otherwise*)?
- \_\_\_\_\_ Are you prone to thrush or cystitis?
- \_\_\_\_\_ Do you often take antibiotics more than twice a year?
- \_\_\_\_\_ Is there a history of cancer in your family?
- \_\_\_\_\_ Have you ever had any growths or lumps biopsied?
- \_\_\_\_\_ Do you have an inflammatory disease such as eczema, asthma or arthritis?
- \_\_\_\_\_ Do you suffer from hayfever?
- \_\_\_\_\_ Do you suffer from allergy problems?
- \_\_\_\_\_ Have you had a major personal loss in the last year?

## Histamine Profile

*Underline the following that apply to you:*

Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious by nature, fat or 'well covered', can tolerate pain.  
Sleep less than 7 hours, strong sex drive, little body hair, family history of allergies, fast metabolism, 'morning person', long toes and fingers, tends towards depression, don't put on weight, poor tolerance of pain.

## Allergy Profile

*Do you suffer from any of the following? Please underline.*

Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.

Do you have any allergies? \_\_\_\_\_ If so what? \_\_\_\_\_

State type of reaction? \_\_\_\_\_

Have they been tested? \_\_\_\_\_

What food or drinks would you find hard to give up?

## Additional Questions for Women Only

- \_\_\_\_\_ Are you pregnant? If so how many weeks? \_\_\_\_\_
- \_\_\_\_\_ Are you trying to become pregnant?
- \_\_\_\_\_ Have you ever had a miscarriage?
- \_\_\_\_\_ Do you have an IUD fitted, or use the birth control pill? State which: \_\_\_\_\_
- \_\_\_\_\_ Are your periods regular?
- \_\_\_\_\_ Are you post-menopausal?
- \_\_\_\_\_ Do you suffer from any pre-menstrual bloatedness, tiredness, irritability, depression, breast tenderness, headaches (*Please underline*)

# DIET ANALYSIS

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

- |  |   |
|--|---|
| <p>1. ___ Were you breast fed?</p> <p>2. ___ Was a significant percentage of your diet as a child high in fatty foods and sugar?</p> <p>3. ___ Do you go out of your way to avoid foods containing preservatives or additives?</p> <p>4. ___ Do you avoid foods which contain sugar?</p> <p>5. ___ How many teaspoons of sugar do you add to food/drinks each day?</p> <p>6. ___ Do you use salt in your cooking?</p> <p>7. ___ Do you add salt to your food?</p> <p>8. ___ How many coffees do you drink each day?</p> <p>9. ___ How many cups of tea do you drink each day?</p> <p>10. ___ How many times a week do you have meals containing fried food?</p> <p>11. ___ How many packets of 'instant' or fast foods do you eat each week?</p> <p>12. ___ How many times a week do you eat chocolate or confectionery?</p> | <p>13. ___ What percentage of your diet is raw fruit and raw vegetables?</p> <p>14. ___ Do you wash fruit and vegetables before eating?</p> <p>15. ___ Do you normally eat white rice or flour?</p> <p>16. ___ How many cans of food do you eat per week?</p> <p>17. ___ How many slices of bread or rolls do you eat each week?</p> <p>18. ___ How many pints of milk do you drink in a week?</p> <p>19. ___ How many times a week do you eat red meat? (beef, pork, lamb or game)</p> <p>20. ___ How many times a week do you eat white meat? (poultry, fish)</p> <p>21. ___ What is your usual alcoholic drink? _____</p> <p>22. ___ How many glasses do you drink a week?</p> <p>23. ___ How many times a week do you eat live yoghurt?</p> <p>24. ___ Do you use a water filter or drink bottled water instead of tap water?</p> <p>25. ___ Do you frequently eat under stressful conditions or on the move?</p> <p>26. ___ Does your job involve eating out a lot?</p> <p>27. ___ How would you describe your appetite?<br/> a) poor                      b) average                      c) good</p> |
|--|---|

**Write down all the foods and drinks consumed over the next two days, starting today.  
Please add as much information as possible including quantities eaten, brand names,  
and whether the food is fresh or packaged, refined or natural.**

**Day 1**

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Breakfast

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Lunch

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Dinner

---

Snacks/Drinks

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**Day 2**

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Breakfast

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Lunch

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Dinner

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Snacks/Drinks

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**Are these two days representative of your usual eating habits? If not, what is a more usual day?**

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Breakfast

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Lunch

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Dinner

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Snacks/Drinks

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**What Nutritional Supplements do you take daily on a regular basis?**

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