

Private and Confidential

Nutrition Programme Questionnaire

This questionnaire is designed to provide me 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: _____

Address: _____

Last Name: _____

Tel. no: _____

Email: _____

Occupation: _____

Age: _____

Your Weight (without clothes): stone lbs

Your Height (without shoes): feet inches

Postcode: _____

Health Profile

Please make a list of all the health problems you would like to clear up, indicating how long you have had these problems. (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 children? If so, state age/sex _____

How many brothers & sisters do you have? State age/sex _____

Are there any particular illnesses that they suffer from? _____

What illness is/was your father prone to? _____

What illness is/was your mother prone to? _____

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Symptom Analysis

Please UNDERLINE any conditions that you regularly experience and CIRCLE any that are a particular problem.

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, difficulty 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, 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

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, difficulty concentrating, easily frustrated, easily distracted, difficult to make decisions, can't switch off, loss of interest in daily life, fogginess, dyslexia, 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, nauseas, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, sharp pain, irritable bowel syndrome, celiac, hiatus hernia, diverticulitis, 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/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.

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LIFESTYLE ANALYSIS

Cardiovascular Profile

- _____ Is your blood pressure above 140/90?
- _____ Is your pulse after 15 minutes rest above 75?
- _____ Are you more than 14 lbs (7 kg) 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?
- _____ Do you have any physically tiring hobbies?
- _____ 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 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 other)?
- _____ 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 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, hayfever, 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 drink 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)

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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.

- _____ Were you breast fed?
- _____ Was a significant percentage of your diet as a child high in fatty foods and sugar?
- _____ Do you go out of your way to avoid foods containing preservatives or additives?
- _____ Do you avoid foods which contain sugar?
- _____ How many teaspoons of sugar do you add to food/drinks each day?
- _____ Do you use salt in your cooking?
- _____ Do you add salt to your food?
- _____ How many coffees do you drink each day?
- _____ How many cups of tea do you drink each day?
- _____ How many times a week do you have meals containing fried food?
- _____ How many packets of 'instant' or fast foods do you eat each week?
- _____ How many times a week do you eat chocolate or confectionary?
- _____ What percentage of your diet is raw fruit and raw vegetables?
- _____ Do you wash fruit and vegetables before eating?
- _____ Do you normally eat white rice or flour?
- _____ How many cans of food do you eat per week?
- _____ How many slices of bread or rolls do you eat each week?
- _____ How many pints of milk do you drink in a week?
- _____ How many times a week do you eat red meat? (beef, pork, lamb or game)
- _____ How many times a week do you eat white meat? (poultry, fish)
- _____ What is your usual alcoholic drink? _____
- _____ How many glasses do you drink a week?
- _____ How many times a week do you eat live yoghurt?
- _____ Do you use a water filter or drink bottled water instead of tap? _____
- _____ Do you frequently eat under stressful conditions or on the move? _____
- _____ Does your job involve eating out a lot? _____
- _____ How would you describe your appetite? Poor / Average / Good (please underline)

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 hear about me? _____
GP's Name: _____
Address: _____

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 to be used by my Nutritional Therapist and for my therapist to liaise with appropriate health professionals.

Signed _____ Date _____

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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. 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

	Weekday 1	Weekday 2	Weekend/Day Off
Break-fast	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snacks	Time:	Time:	Time:
Drinks	___ coffees (___ sugars) ___ 'normal' tea (___ sugars) ___ green/herbal tea ___ fizzy drinks/cordial ___ units of alcohol ___ glasses of water Other drinks...	___ coffees (___ sugars) ___ 'normal' tea (___ sugars) ___ green/herbal tea ___ fizzy drinks/cordial ___ units of alcohol ___ glasses of water Other drinks...	___ coffees (___ sugars) ___ 'normal' tea (___ sugars) ___ green/herbal tea ___ fizzy drinks/cordial ___ units of alcohol ___ glasses of water Other drinks...

Your Routine

	Day 1	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