

NUTRITIONAL THERAPY QUESTIONNAIRE

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This questionnaire is designed to provide your nutritional therapist with all the information necessary to build an individual nutrition and lifestyle programme tailored to your specific needs. Please answer the questions as accurately as you can.

First Name: _____ Last Name: _____ DOB: _____

Address:	GP Name:
Postcode:	GP Address:
Telephone Home:	Postcode:
Work:	Telephone:
Mobile:	May your GP be contacted? YES / NO
Email:	Is your GP aware of your intention to seek nutritional advice? YES / NO
Marital Status:	Children/Dependents (age):
Occupation:	Blood Pressure (if known):
Weight: Height:	Cholesterol levels (if known):
Hobbies/Relaxation:	
Exercise (please specify):	Do you enjoy exercise? YES / NO
Would you describe yourself as SEDENTARY <input type="checkbox"/> MODERATELY ACTIVE <input type="checkbox"/> ACTIVE <input type="checkbox"/> VERY ACTIVE <input type="checkbox"/>	
Do you smoke? YES ____ per day / NO Drink alcohol? NO / YES, usual drink _____ Units per week ____	
Are you currently following a medically prescribed diet?	
Have you seen/are you currently seeing a nutritionist, homeopath or other health practitioner (please specify)?	

Please list any nutritional supplements, herbs, homeopathic and other remedies you are currently taking and why, giving manufacturer's name and dosage (please bring with you to the consultation if possible):

CURRENT HEALTH GOALS:

1.
2.
3.

Please sign below to confirm that:

- The medical and other information given in this form is accurate to the best of your knowledge.
- You understand that as a nutritional therapist I am not able to diagnose or treat medical conditions, and that nutritional advice is not intended to replace the advice of a medical doctor or substitute professional medical treatment.
- You understand that good nutrition helps to build the body's natural strength and resistance and no claim is made to the certain efficacy of any dietary protocols.

Signature: _____ Date: _____

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PERSONAL HEALTH HISTORY

Starting with the most recent first, please list any *current and past* accidents/illnesses/operations you have suffered, stating date of onset, duration and any medications used (please continue on separate sheet if necessary):

Health problem	Approx Date & Duration	Medication/Management

Please list any regular medications, including over the counter drugs, you are presently taking but have not stated above e.g. HRT, the contraceptive pill, ibuprofen, sleeping pills etc.

Have you taken antibiotics? YES / NO Have you suffered unexplained weight gain or loss? YES / NO

Have you experienced digestive problems as a result of gut infections/food poisoning/foreign travel? Please specify

Is there a history of particular illnesses or conditions in your family (siblings, parents, aunts/uncles, grandparents) such as heart disease, diabetes etc?

KEY SYMPTOMS THAT MAY NEED MEDICAL REFERRAL. Please tick if yes to the following questions:

- | | | |
|--|--|--|
| Any unexplained pain <input type="checkbox"/> | Chest pain <input type="checkbox"/> | Loss of appetite <input type="checkbox"/> |
| Bleeding from nipple <input type="checkbox"/> | Constipation <input type="checkbox"/> | Numbness or paralysis <input type="checkbox"/> |
| Bleeding from vagina <input type="checkbox"/> | Depression <input type="checkbox"/> | Persistent cough <input type="checkbox"/> |
| Blood in stool <input type="checkbox"/> | Diarrhoea <input type="checkbox"/> | Persistent nose bleeds <input type="checkbox"/> |
| Blood in urine <input type="checkbox"/> | Difficulty swallowing <input type="checkbox"/> | Shortness of breath <input type="checkbox"/> |
| Blood in vomit <input type="checkbox"/> | Discharge from vagina <input type="checkbox"/> | Slurred speech <input type="checkbox"/> |
| Blurred vision or dizziness <input type="checkbox"/> | Excessive thirst <input type="checkbox"/> | Unexplained bruising <input type="checkbox"/> |
| Breast lumps <input type="checkbox"/> | Frequent urination <input type="checkbox"/> | Unexplained heavy periods <input type="checkbox"/> |
| Changes in nature of moles <input type="checkbox"/> | Headaches <input type="checkbox"/> | Unexplained weight loss <input type="checkbox"/> |

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SIGNS AND SYMPTOMS CHECKLIST

Below is a list of symptoms associated with nutritional deficiencies. Please tick all relevant symptoms, underlining any that particularly apply. Some symptoms are repeated – please tick or underline them each time they occur.

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Burning or gritty eyes | <input type="checkbox"/> Poor hair condition | <input type="checkbox"/> Muscle cramps or tremors |
| <input type="checkbox"/> Poor night vision | <input type="checkbox"/> Sensitivity to bright lights | <input type="checkbox"/> Eczema or dermatitis | <input type="checkbox"/> Insomnia or nervousness |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Sore tongue | <input type="checkbox"/> Mouth over sensitive to hot or cold | <input type="checkbox"/> Joint pain or arthritis |
| <input type="checkbox"/> Frequent colds or infections | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Irritability | <input type="checkbox"/> Tooth decay |
| <input type="checkbox"/> Dry flaky skin | <input type="checkbox"/> Dull or oily hair | <input type="checkbox"/> Anxiety or tension | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema or dermatitis | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Pale skin |
| <input type="checkbox"/> Thrush or cystitis | <input type="checkbox"/> Split nails | <input type="checkbox"/> Constipation | <input type="checkbox"/> Sore tongue |
| <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Cracked lips | <input type="checkbox"/> Tender or sore muscles | <input type="checkbox"/> Fatigue or listlessness |
| | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Pale skin | <input type="checkbox"/> Loss of appetite or nausea |
| <input type="checkbox"/> Rheumatism or arthritis | <input type="checkbox"/> Diarrhoea | <input type="checkbox"/> Eczema | <input type="checkbox"/> Heavy periods or blood loss |
| <input type="checkbox"/> Back ache | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Cracked lips | |
| <input type="checkbox"/> Tooth decay | <input type="checkbox"/> Headaches or migraine | <input type="checkbox"/> Prematurely greying hair | <input type="checkbox"/> Poor sense of taste or smell |
| <input type="checkbox"/> Hair loss | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Anxiety or tension | <input type="checkbox"/> White marks on more than two finger nails |
| <input type="checkbox"/> Excessive sweating | <input type="checkbox"/> Anxiety or tension | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Muscle cramps/spasms | <input type="checkbox"/> Depression | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Stretch marks |
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Irritability | <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Acne or greasy skin |
| <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Bleeding or tender gums | <input type="checkbox"/> Stomach pains | <input type="checkbox"/> Low fertility |
| | <input type="checkbox"/> Acne | <input type="checkbox"/> Depression | <input type="checkbox"/> Pale skin |
| <input type="checkbox"/> Lack of sex drive | <input type="checkbox"/> Muscle tremors or cramps | <input type="checkbox"/> Dry skin | <input type="checkbox"/> Tendency to depression |
| <input type="checkbox"/> Exhaustion after light exercise | <input type="checkbox"/> Apathy | <input type="checkbox"/> Poor hair condition | <input type="checkbox"/> Poor appetite |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Prematurely greying hair | |
| <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Burning feet or tender heels | <input type="checkbox"/> Tender or sore muscles | <input type="checkbox"/> Muscle twitches |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Poor appetite or nausea | <input type="checkbox"/> Childhood growing pains |
| <input type="checkbox"/> Loss of muscle tone | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Eczema or dermatitis | <input type="checkbox"/> Dizziness or poor sense of balance |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Exhaustion after light exercise | <input type="checkbox"/> Dry, rough or scaly skin | <input type="checkbox"/> Fits or convulsions |
| | <input type="checkbox"/> Anxiety or tension | <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Sore knees |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Teeth grinding | <input type="checkbox"/> Frequent infections | |
| <input type="checkbox"/> Lack of energy | | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Family history of cancer |
| <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Infrequent dream recall | <input type="checkbox"/> Loss of hair or dandruff | <input type="checkbox"/> Signs of premature ageing |
| <input type="checkbox"/> Bleeding/tender gums | <input type="checkbox"/> Water retention | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Cataracts |
| <input type="checkbox"/> Easy bruising | <input type="checkbox"/> Tingling hands | <input type="checkbox"/> Poor wound healing | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Depression or nervousness | <input type="checkbox"/> PMS or breast pain | <input type="checkbox"/> Frequent infections |
| <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Irritability | <input type="checkbox"/> Infertility | |
| <input type="checkbox"/> Red pimples on skin | <input type="checkbox"/> Muscle tremors or cramps | <input type="checkbox"/> Muscle cramps or spasms | <input type="checkbox"/> Excessive or cold sweats |
| | <input type="checkbox"/> Lack of energy | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Dizziness or irritability after 6 hours without food |
| <input type="checkbox"/> Tender muscles | <input type="checkbox"/> Flaky skin | <input type="checkbox"/> Insomnia or nervousness | <input type="checkbox"/> Need for frequent meals |
| <input type="checkbox"/> Eye pains irritability | | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Poor concentration | | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Need for excessive sleep or drowsiness during the day |
| <input type="checkbox"/> Prickly legs | | <input type="checkbox"/> Constipation | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Poor memory | | <input type="checkbox"/> Fits or convulsions | <input type="checkbox"/> "Addicted" to sweet foods |
| <input type="checkbox"/> Stomach pains | | <input type="checkbox"/> Hyperactivity | |
| <input type="checkbox"/> Constipation | | <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Tingling hands | | | |
| <input type="checkbox"/> Rapid heart beat | | | |

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SYMPTOM ANALYSIS – please tick all relevant symptoms underlining any that particularly apply

Digestion Profile

- Anal irritation
- Bloating
- Bolting or rushing meals/eating on the move
- Coated tongue or bad breath
- Constipation
- Diarrhoea
- Haemorrhoids/piles
- Indigestion or heartburn
- Mucus or blood in the stools
- Nausea or vomiting
- Not chewing thoroughly
- Passing wind/flatulence or belching
- Reflux
- Stomach pains or prone to stomach upsets

Cardiovascular Profile

- Abdominal weight gain
- Anaemia
- Chest pains
- Dizziness on standing
- Feel stressed
- High blood fats - cholesterol, triglycerides
- High or low blood pressure
- Irregular or rapid heart beat
- Migraines or headaches
- Poor circulation – cold hands and feet
- Smoker
- Varicose veins
- Weight control problems

Immune Profile

- Arthritis or inflammation
- Asthma or bronchitis
- Bleeding or tender gums
- Chemical sensitivities
- Colds/infections hard to shift
- Do you often take antibiotics
- Eczema or dermatitis
- Frequent colds or infections
- Hayfever
- Joint pain or stiffness
- Mouth ulcers
- Nasal problems, please specify _____
- Other allergy, please specify _____
- Prone to cold sores or herpes
- Prone to thrush or cystitis
- Slow wound healing
- Water retention

Stress Profile

- Anxiety or tension
- Craving salty foods
- Difficulty getting to sleep/insomnia
- Dizzy on standing
- Extreme exhaustion
- Hair loss
- Hot flushes or night sweats
- Hyperactivity or restlessness
- Irritable/easily angered
- Lack of energy or fatigue
- Low body temperature, always feel cold
- PMS or low sex drive
- Severe or recurrent stress
- Slow recovery from stress
- Sweat a lot

How well do you respond to stress on a scale of 0-10?
0 = poorly 5 = reasonably well 10 = very well
Score 0-10 _____

Glucose Tolerance Profile

- Craving for sweet foods or stimulants
- Drowsiness during the day
- Headaches
- Irritable, dizzy, weak or shaky if meals missed
- Lack of energy or fatigue
- Mood swings
- Need for excessive sleep
- Need for frequent meals
- Poor concentration or memory
- Slow to wake up or wake feeling unrefreshed
- Tendency to depression or feeling low
- Very thirsty or frequent urination
- Weight control problems

Inflammation Profile

- Acne
- Arthritis
- Asthma or bronchitis
- Back pain
- Breast tenderness
- Dry, flaky or itchy skin
- Eczema, psoriasis or dermatitis
- Hayfever
- IBS
- Joint pain or stiffness
- PMT
- Rashes
- Rhinitis, sinus problems

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SYMPTOM ANALYSIS – please tick all relevant symptoms underlining any that particularly apply

Female Hormone Profile

- | | |
|--|---|
| <input type="checkbox"/> Are you pregnant? If so, how many weeks? _____ | <input type="checkbox"/> Do you have a low sex drive? |
| <input type="checkbox"/> Are you trying to become pregnant? | <input type="checkbox"/> Do you suffer from pre-menstrual syndrome (PMS)? |
| <input type="checkbox"/> Are you having difficulty conceiving? | Please circle all relevant symptoms: fatigue, anxiety, nervous tension, irritability, mood swings, sweet craving, low sex drive, increased appetite, bloating, breast tenderness, depression, other _____ |
| <input type="checkbox"/> Have you ever had a miscarriage? | <input type="checkbox"/> Have you been diagnosed with PCOS or endometriosis? |
| <input type="checkbox"/> Are you undergoing fertility treatment? _____ | <input type="checkbox"/> Do you have any cysts or fibroids? |
| <input type="checkbox"/> Do you use the contraceptive Pill? _____ | <input type="checkbox"/> Is there any breast or other female related cancer in your family? _____ |
| <input type="checkbox"/> Do you have contraceptive implants? _____ | <input type="checkbox"/> Are you menopausal or post menopausal? |
| <input type="checkbox"/> Have you used the Pill or implants in the past? _____ | <input type="checkbox"/> How long ago was your last period? _____ |
| <input type="checkbox"/> Do you have an IUD fitted? State which _____ | <input type="checkbox"/> Are you taking/have you taken hormone replacement therapy (HRT)? _____ |
| <input type="checkbox"/> Are your periods regular? _____ | |
| <input type="checkbox"/> How many days is your whole cycle? _____ | |
| <input type="checkbox"/> Are your periods heavy or painful? _____ | |

Male Hormone Profile

- | | |
|---|---|
| <input type="checkbox"/> Have you experienced abdominal weight gain | <input type="checkbox"/> Do you experience excessive sweating? |
| <input type="checkbox"/> Do you suffer from acne? | <input type="checkbox"/> Do you suffer from impotence ? |
| <input type="checkbox"/> Have you noticed an altered urine flow? | <input type="checkbox"/> When was your last prostate check? _____ |
| <input type="checkbox"/> Have you been diagnosed with BHP or prostate cancer? | <input type="checkbox"/> Do you have a low sperm count |
| <input type="checkbox"/> Do you suffer from depression? | <input type="checkbox"/> Do you have a low sex drive? |

Are there any times, seasons, events, environments, or foods that cause your symptoms to worsen?

DIETARY ANALYSIS

- | | | |
|--|--|--------|
| Who usually does the shopping? _____ | Do you take time to eat your food | YES/NO |
| Is shopping easy for you? _____ | When is your main meal? LUNCHTIME <input type="checkbox"/> EVENING <input type="checkbox"/> | |
| At which store do you normally buy food? _____ | Do you eat out frequently? | YES/NO |
| In your household, is the majority of the cooking done by: _____ | YOURSELF <input type="checkbox"/> YOUR PARTNER <input type="checkbox"/> SHARED <input type="checkbox"/> OTHER <input type="checkbox"/> | |
| Do you enjoy food preparation? _____ | Do you eat when you are on the move? | YES/NO |
| Do you cook for more than one _____ | Do you eat when you are stressed? | YES/NO |
| Do you cater for a special diet in the family? _____ | Have you experienced an eating disorder? | YES/NO |
| Are you a vegetarian or vegan? _____ | Is your diet repetitive? | YES/NO |
| Do you have any special needs/religious or cultural requirements for food? _____ | | |
| Name any specific diets you have tried or are currently on _____ | | |
| How would you describe your appetite? POOR/AVERAGE/ GOOD | Do you enjoy your food? | YES/NO |
| Do you miss meals? YES/NO/SOMETIMES If so which? _____ | | |
| What are your favourite foods? _____ | | |
| What foods do you dislike? _____ | | |
| Are there any foods that you crave? _____ | | |
| Are there any foods that you avoid? _____ | | |
| Are there any foods you would find hard to give up? _____ | | |

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DIETARY ANALYSIS

How often do you eat the following foods? – Please indicate the number of times as applicable

How many biscuits a week?	.....	Servings of poultry in a week?	.....
How many cakes/pastries a week?	.....	How many eggs a week?	.....
How many cups of coffee a day?	.....	How many glasses of water a day?	.....
How many cups of tea a day?	.....	How many raw salads in a week?	.....
How many pints of milk a week?	.....	How much pasta a week?	.....
How much chocolate a week?	.....	How many slices of bread a day?	.....
Servings of red meat in a week?	.....	How much cheese a week?	.....
Servings of white fish in a week?	.....	How much fruit a day?	.....
Servings of oily fish in a week?	.....	How many servings of vegetables a day?	.....
Servings of processed meat in a week?	.....	How much live yoghurt a week?	.....
Servings of breakfast cereals in a week?	.....	How many soya products a week?	.....
Ready meals a week?	.....	Takeaways a week?	.....
Restaurant meals a week?	.....	Home-cooked meals a week?	.....

Please tick if yes to the following questions – do you:

Add salt to cooking or food?	<input type="checkbox"/>	Avoid additives and preservatives?	<input type="checkbox"/>
Add sugar to food or drink?	<input type="checkbox"/>	Choose mainly low fat foods?	<input type="checkbox"/>
Drink fizzy drinks?	<input type="checkbox"/>	Dilute fruit juices?	<input type="checkbox"/>
Add prepared pickles/vinegar to meals?	<input type="checkbox"/>	Drink mainly bottled water?	<input type="checkbox"/>
Add prepared sauces/ketchups to meals?	<input type="checkbox"/>	Drink mainly filtered water?	<input type="checkbox"/>
Mainly cook with vegetable oils?	<input type="checkbox"/>	Drink mainly organic beverages?	<input type="checkbox"/>
Mainly drink tap water?	<input type="checkbox"/>	Eat mainly fresh fruit and vegetables?	<input type="checkbox"/>
Mainly eat white bread?	<input type="checkbox"/>	Eat mainly wholegrain bread, pasta & cereals?	<input type="checkbox"/>
Mainly use margarines?	<input type="checkbox"/>	Regularly drink herbal teas?	<input type="checkbox"/>
Regularly consume gum, toffees and sweets?	<input type="checkbox"/>	Regularly eat beans and lentils?	<input type="checkbox"/>
Regularly eat fried food?	<input type="checkbox"/>	Regularly eat nuts and seeds?	<input type="checkbox"/>
Regularly eat processed foods?	<input type="checkbox"/>	Use olive oil/butter for cooking?	<input type="checkbox"/>
Regularly eat salted/roasted nuts?	<input type="checkbox"/>	Were you raised on a healthy diet?	<input type="checkbox"/>
Regularly eat take-away meals?	<input type="checkbox"/>	Were you breastfed?	<input type="checkbox"/>
Wash/peel fruit and veg before eating?	<input type="checkbox"/>	Regularly eat tinned food?	<input type="checkbox"/>

Please circle any of the following ways you prepare food: GRILL BAKE FRY STIR FRY MICROWAVE BOIL RAW

Do you eat organic food? YES/NO/SOMETIMES State which type _____

How would you describe your feelings about changing how you eat and experimenting with new foods?

I feel anxious about changing my diet	<input type="checkbox"/>	I can cope with a moderate amount of change	<input type="checkbox"/>
I am willing to try anything that might improve my symptoms	<input type="checkbox"/>		

Additional comments and considerations:

Thank you for taking the time to fill in this questionnaire. Please return to my clinic address with your food diary ASAP.