Sarah Zorab Nutrition

Nutritional Questionnaire

Please give as much detail as possible.

PRIVATE AND CONFIDENTIAL

Client

Name: Address:

Date of consultation:

D.O.B:

Email:

Telephone: Postcode:

Current Health / Dietary Goals – the reasons for booking the consultation:

Under what circumstances do these problems get worse?

General Health and Lifestyle

Marital Status: Children / Dependents:

Occupation: Height: Weight:

Hobbies/Relaxation: Blood Pressure (if known):

Please list any nutritional supplements / herbs you are presently taking, giving manufacturers name and dosage:

Do you take exercise? Please specify:

Do you smoke? Yes ☐ No ☐ If yes, how many per week:

Do you drink alcohol? Yes ☐ No ☐ If yes, how many units per week:

Medical History

Please list all the health problems concerning you, how long you have had them and medication/dosage. e.g. headaches - 2years - aspirin. List them in order of priority if possible. Please also include medication such as the Pill and HRT.

Health problem	Duration	Medication/dosage

Add details of major surgery and or trauma (physical and emotional) that you have experienced in your lifetime – indicating dates as appropriate.

Do you suffer from stress? Yes ☐ No ☐

On a scale of 1-10 what is your current stress level?

Do you have a daily bowel movement? Yes ☐ No ☐

Have you taken antibiotics recently? Yes ☐ No ☐

Have you experienced digestive problems as a result of gut infections/food poisoning and were they a result of travelling abroad?

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

Please print/sign your name below to confirm that:

You understand that nutritional therapy is not a substitute for professional medical treatment.

Patient Name: Date:

Sign or Symptoms Checklist

Please tick anything below you have suffered significantly from in the past 6 months:

- ☐ Bolting or rushing meals
- ☐ Indigestion or heartburn
- ☐ Coated tongue or bad breath
- ☐ Constipation
- ☐ Bloating
- ☐ Anal irritation
- ☐ Mucus or blood in the stools
- ☐ Diarrhoea
- ☐ Nausea or vomiting
- ☐ Stomach pains or prone to stomach upsets
- ☐ Passing wind/flatulence
- ☐ Irregular or rapid heart beat
- ☐ Chest pains
- ☐ High blood fats - cholesterol, triglycerides
- ☐ Frequent colds or infections
- ☐ Mouth ulcers
- ☐ Bleeding or tender gums
- ☐ Sweat a lot
- ☐ Strong body odour
- ☐ Slow wound healing
- ☐ Prone to thrush or cystitis
- ☐ Prone to cold sores or herpes
- ☐ Hayfever
- ☐ Other allergy, please specify:
- ☐ Chemical sensitivities
- ☐ Lack of energy or fatigue
- ☐ Irritable, dizzy, weak or shaky if meals missed
- ☐ Very thirsty or frequent urination
- ☐ Slow to wake up or wake feeling unrefreshed
- ☐ Weight control problems
- ☐ Drowsiness during the day
- ☐ Craving for sweet foods or stimulants
- ☐ Headaches / Migraines
- ☐ Poor concentration or memory
- ☐ Tendency to depression or feeling low
- ☐ Need for excessive sleep
- ☐ Mood swings
- ☐ Anxiety or tension
- ☐ Irritability or easily become angry
- ☐ Hyperactivity or restlessness
- ☐ Severe or recurrent stress
- ☐ Insomnia
- ☐ Low body temperature / Cold hands or feet
- ☐ Dry, flaky or itchy skin
- ☐ Eczema or dermatitis
- ☐ Acne
- ☐ Rosacea
- ☐ Peeling, soft or splitting nails
- ☐ Hair loss or poor condition
- ☐ Dizzy on standing
- ☐ Rings round the eyes or puffy eyes
- ☐ High or low blood pressure
- ☐ Anaemia
- ☐ Sore tongue
- ☐ Asthma or bronchitis
- ☐ Nasal problems, please specify:
- ☐ Water retention
- ☐ Joint pain or stiffness
- ☐ Gout
- ☐ Transverse grooves or brittle nails
- ☐ Muscle aches, cramps or spasm
- ☐ Low bone density
- ☐ Osteoarthritis or Rheumatoid arthritis
- ☐ Muscle weakness
- ☐ Osteopenia or osteoporosis
- ☐ Back pain
- ☐ Kidney stones
- ☐ Gall stones

Dietry Checklist

In addition to filling in the food diary, please answer the following questions:
(e.g. Live yoghurt:2)

How many times a week do you eat:

Live yoghurt:

Raw Vegetables:

Ham/bacon:

Fish - State which:

Cheese:

Chocolate:

Cakes/biscuits:

Pasta / Race / Potatoes

Breakfast cereals: State which:

Salads:

Processed meats (salami, sausages, hambuergers etc):

Red meat (beef, lamb, pork):

Nuts & Seeds:

Beans & Pulses:

Eggs:

Home cooked meals:

Ready meals:

Eat out:

How much of the following do you consume a day?

Fresh fruit: ____ portions

Vegetables (not including potatoes): ____ portions

Slices of bread / rolls: ____ State type e.g. white, wholemeal: _____

Milk: _____ pints

State type: e.g. cow's whole / semi-skimmed / skimmed: _____

Coffee: ____ cups or mugs

Tea: ____ cups or mugs

Water: ____ glasses

Fizzy drinks: ____ State type: _____

Sugar / Sweetener: ____ State type: _____

Other questions

Do you miss meals? If so which?

Do you enjoy food preparation? Yes ☐ No ☐

Do you eat at stressful times or on the move? Yes ☐ No ☐

How would you describe your appetite? Poor ☐ Average ☐ Good ☐

Please circle any of the following special diets you are on now:

Vegtarian (with fish) Vegetarian (without fish) Vegan Gluten Free Diabetic Low cholesterol Weight loss

Other, please specify:

Please list the five foods you most like:

Please list the five foods you most dislike:

For Women Only

Are you pregnant? If so, how many weeks?

Are you having difficulty conceiving? Yes ☐ No ☐

Do you have a IUD fitted? State which:

Do you use the contraceptive pill? State which:

Are your periods regular? Yes ☐ No ☐

Are your periods heavy or painful? Yes ☐ No ☐

Do you suffer from Pre-menstrual syndrome (PMS)? Yes ☐ No ☐

Circle the symptom(s): fatigue, anxiety, nervous tension, irritability, mood swings, sweet craving, increased appetite, bloating, breast tenderness, depression, night sweats, vaginal dryness, other.

Are you menopausal or post menopausal?

Food Diary

To understand how you put your meals together, please list all foods and drinks consumed over an average 3 day period. Try to include two weekdays and one weekend day. Please list everything you eat , including condiments and sauces. Give as much information as you are able, such as the brand name, portion size, whether the food is fresh or pre-packed and how it is cooked. Please include all drinks, even water. Example; Breakfast 7.30am – 1 bowl Kelloggs's cornflakes with semi-skimmed milk (no sugar) and 1 cup instant coffee (black no sugar).

Weekday		Weekday		Weekend day	
Breakfast	Time	Breakfast	Time	Breakfast	Time
Mid Morning	Time	Mid Morning	Time	Mid Morning	Time
Lunch	Time	Lunch	Time	Lunch	Time
Mid Morning	Time	Mid Morning	Time	Mid Morning	Time
Dinner	Time	Dinner	Time	Dinner	Time
After Dinner	Time	After Dinner	Time	After Dinner	Time