



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:

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

Breakfast cereals: State which:

Salads:

Processed meats (salami, sausages, hamburgers 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:

Vegitarian (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:

Are your periods regular? 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?

Do you use the contraceptive pill? State which:

Are your periods heavy or painful? Yes No

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