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**This information will be treated as strictly confidential**

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| NUTRITIONAL THERAPY QUESTIONNAIRE |

*Please answer questions as accurately as you can. The information you give will help your treatment.*

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| GENERAL INFORMATION |

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| --- | --- | --- |
| Name: | | Title: |
|  |  | |
| Address: | Tel.No Day: | |
|  | Tel No. Evening: | |
|  | Mobile: | |
|  | E-mail: | |
|  | Date of Birth: | |
|  | Height: Weight: | |
| GP name & address: |
|  | Blood pressure: | |
|  | |
| GP tel no: | Permission to contact GP: Yes / No | |
|  |  | |
| Occupation: | Details of any dependants: (inc. age) | |

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| REASONS FOR VISITING THE NUTRITION CLINIC |

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| Please list the main health areas you would like to address. |
| 1. |
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| 2. |
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| 3. |
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| Are there any times, seasons, environments or places that cause your symptoms to worsen? Please provide details: *(eg – before/after meals, heavy traffic, etc)*  Is your diet based on any religious, personal or other choice (e.g. Hindu, Muslim, vegetarian, vegan etc):  *Please specify*  Do you have any special dietary requirements? Yes / No If so, what are they?  List any specific foods you avoid for personal or medical reasons. |

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| MEDICAL HISTORY |

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| Please list any illnesses/operations (excluding colds & flu) starting from childhood and including any current health concerns. *(Please continue on an additional sheet if necessary)* | | | |
| Your health history illnesses & operations | Age of onset | Duration | Medication (include current medication) |
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| Please specify any regular medication you may be taking: (*ie: aspirin, HRT, painkillers, contraceptive pill etc)* |

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| Please specify if you are currently undergoing any form of medical treatment: | When did you last take antibiotics? |

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| Are you currently taking any nutritional supplements, herbs or homoeopathic remedies? Please list, giving the dosage and manufacturers name:  *(It would be very helpful if you could bring the above to your consultation)* |

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| What (if any) illnesses are present on your mother and fathers side of the family?  If you have siblings, do they have any illnesses? |

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| LIFESTYLE |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Would you describe yourself as: | | | | | | |
| Sedentary | 🞎 | Moderately active | 🞎 | Active | 🞎 Very active | 🞎 |

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| What is your average intake of alcohol? | Do you smoke? Yes / No |
| Weekday: | If so, how many per day? |
| Weekend: | If you did smoke, when did you give up? |

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| How motivated are you to change the way you eat and to experiment with new foods? (*Please tick)*  I am willing to try anything that might improve my condition 🞎  I feel I can cope with a moderate amount of change 🞎  I feel anxious about changing my diet 🞎 |

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| **HEALTH SCREEN**  If you have any of the following symptoms, please tick the box that indicates the severity of your symptoms.  1 = Mild 2 = Moderate 3 = Severe |

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| 1 | 2 | 3 | SECTION 1 |  | 1 | 2 | 3 | SECTION 9 |
|  |  |  | Poor memory |  |  |  |  | Nausea or vomiting |
|  |  |  | Confusion, poor comprehension |  |  |  |  | Diarrhoea |
|  |  |  | Poor concentration |  |  |  |  | Constipation |
|  |  |  | Poor physical co-ordination |  |  |  |  | Bloated feeling |
|  |  |  | Difficulty making decisions |  |  |  |  | Belching, or passing wind |
|  |  |  | Are any of the above made worse by skipping a meal |  |  |  |  | Heartburn |
|  |  |  |  |  |  |  |  |  |
| 1 | 2 | 3 | SECTION 2 |  | 1 | 2 | 3 | SECTION 10 |
|  |  |  | Headache |  |  |  |  | Acne |
|  |  |  | Faintness or dizziness |  |  |  |  | Hives, rash or dry skin |
|  |  |  | Insomnia |  |  |  |  | Hair loss |
|  |  |  |  |  |  |  |  | Flushing or hot flushes |
| 1 | 2 | 3 | SECTION 3 |  |  |  |  | Excessive sweating |
|  |  |  | Watery or itchy eyes |  |  |  |  | Soft, fraying or brittle nails |
|  |  |  | Swollen, reddened, sticky eyelids |  |  |  |  |  |
|  |  |  | Sensitive to bright light |  | 1 | 2 | 3 | SECTION 11 |
|  |  |  | Blurred or tunnel vision (does not include near or far sight) |  |  |  |  | Water retention |
|  |  |  |  |  |  |  |  | Binge eating or drinking |
| 1 | 2 | 3 | **SECTION 4** |  |  |  |  | Cravings for certain foods |
|  |  |  | Itchy ears |  |  |  |  | Lack of appetite |
|  |  |  | Earaches, ear infection |  |  |  |  | Compulsive eating |
|  |  |  | Discharge from ear |  |  |  |  |  |
|  |  |  | Ringing in ears, hearing loss |  | 1 | 2 | 3 | SECTION 12 |
|  |  |  |  |  |  |  |  | Frequent illness |
| 1 | 2 | 3 | SECTION 5 |  |  |  |  | Frequent or urgent urination |
|  |  |  | Stuffy nose or Sinus problems |  |  |  |  | General itch or discharge |
|  |  |  | Hay fever |  |  |  |  | Excessive thirst |
|  |  |  | Excessive mucus formation |  |  |  |  | Loss of taste or smell |
|  |  |  | Sensitive to strong smells e.g. perfume, petrol etc |  |  |  |  |  |
|  |  |  |  |  | 1 | 2 | 3 | SECTION 13 female only |
| 1 | 2 | 3 | SECTION 6 |  |  |  |  | Menstrual pain |
|  |  |  | Chronic cough |  |  |  |  | Tender/painful breasts |
|  |  |  | Gagging |  |  |  |  | Mood change before period |
|  |  |  | Frequent need to clear throat |  |  |  |  |  |
|  |  |  | Sore throat, hoarseness, loss of voice |  | 1 | 2 | 3 | SECTION 14 male only |
|  |  |  | Sore tongue |  |  |  |  | Difficulty urinating |
|  |  |  | Prone to cold sores |  |  |  |  | Loss of libido |
|  |  |  |  |  |  |  |  | Mood changes |
| 1 | 2 | 3 | SECTION 7 |  |  |  |  |  |
|  |  |  | Irregular or skipped heartbeat |  | 1 | 2 | 3 | SECTION 15 |
|  |  |  | Rapid or pounding heartbeat |  |  |  |  | Mood swings |
|  |  |  | Chest pain |  |  |  |  | Anxiety, fear or nervousness |
|  |  |  |  |  |  |  |  | Anger, irritability, aggressiveness |
| 1 | 2 | 3 | SECTION 8 |  |  |  |  | Depression |
|  |  |  | Chest congestion/wheezing |  |  |  |  |  |
|  |  |  | Asthma |  | 1 | 2 | 3 | SECTION 16 |
|  |  |  | Shortness of breath |  |  |  |  | Fatigue, sluggishness |
|  |  |  | Difficulty breathing |  |  |  |  | Apathy, lethargy |
|  |  |  |  |  |  |  |  | Hyperactivity |
|  |  |  |  |  |  |  |  | Restlessness |

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| DIETARY ANALYSIS |

Are there any foods that you crave? …………………………………………………………………………………......

Are there any foods you dislike? ............................................................................................................................

Have you followed any special diets in the past or at present? .............................................................................

Have you experienced an eating disorder? 🞎

Do you eat out frequently? 🞎

Do you enjoy eating & preparing food? 🞎

Do you have a good appetite? 🞎

Is shopping easy for you? 🞎

Do you cook for more than one? 🞎

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| FOOD DIARY |

Please fill in the food diary as accurately as possible to give a guide to your typical diet. Include a working day and a day off with times of eating and drinking. Put down approximate portion sizes and any physical symptoms you felt during the day.

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| --- | --- | --- | --- |
| **Date: Food and Drink consumed** (Typical Weekday) | | | |
| **Time:** | **Quantity:** |  | **Symptom:** |
| **Date: Food and Drink consumed** (Typical Weekend Day) | | | |
| **Time:** | **Quantity:** |  | **Symptom:** |

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| ANY ADDITIONAL COMMENTS: (eg: is the above typical of your regular diet) |

Thank you for completing this questionnaire. *Please bring this questionnaire to your consultation.*

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| **I confirm that all information included on the questionnaire is correct to the best of my knowledge. I understand that**  **Nutritional therapy is not a substitute for professional medical treatment.** |

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| Once you have completed the questionnaire, **please sign:**  **Date:** |  |