

Nutritional Therapy Questionnaire

Please provide details as fully and accurately as possible. If at any time you need more space please continue on a separate sheet.

Title _____ First Name _____ Last Name _____ Date of Birth _____ Age _____

Address _____

Post Code _____ E-Mail _____ Phone Numbers _____

Occupation _____ Work environment (e.g. city, farm) _____

Health Profile

What is your main reason for seeking nutritional advice? _____

What outcome are you hoping to achieve? _____

Please list any health problems you would like to focus on. Continue on a separate sheet if you need more space.

Health Problem (e.g. arthritis)	Management so far (e.g. GP, operation, exercise, paracetamol etc)	Onset (date)	Duration
1.			
2.			
3.			

Have you had any recent health tests? Please specify or attach, if appropriate _____

Have you had any other major surgery, biopsies, diagnosed medical conditions, Significant periods of ill health or do you suffer from any niggling health problems? (please give details e.g. high blood pressure, frequent colds, recurrent urinary infections etc) _____

Do you suspect you symptoms relate to a particular event or time in your life? _____

How do you feel about including supplements in any plan devised by your therapist? **Yes/Consider/No**

Medication & Remedies

Please list anything you take regularly including GP prescribed medication, self-prescribed medication (e.g. painkillers) nutritional supplements, herbal or homeopathic remedies. Continue on a separate sheet if necessary

Remedy	Dose	Condition being treated	Frequency & Duration

Antibiotic history. Please state when and why you last took antibiotics plus any previous times you can remember

Body Scan

Head

Headaches, migraine, stiff neck, fuzzy headed, dizziness,
Poor balance, pounding head, feeling of hangover,
Unexplained pain

Hair

Oily, dry, poor condition, brittle, thinning, prematurely grey,
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, difficult swallowing
Hoarse voice, gingivitis, bleeding gums, cold sores

Eyes

Burning, gritty, protruding, prone to infection, sticky, itch, 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

Muscles

Tender, sore, cramps, spasms, twitches, loss of tone, wasting,
weak, stiff, frozen, restless legs, numbness

Skin

Dry, rough, flaky, scaly, puffy, pale brown, patches, change in
moles or lesions, prematurely lined, congested, oily, clammy,
yellow

Skin prone to

Acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes,
boils, hives, itching, stretch marks, cellulite, easy bruising,
thread veins, varicose veins, ringworm, allergic reactions,
excessive sweating

Joints (fingers, knees, back, shoulders etc)

Painful, inflamed swollen, stiff rheumatic, arthritic, aching,
difficulty bending, reduced mobility, unsteadiness, slow
movement

Please UNDERLINE any conditions that you regularly experience

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, suicidal, fluctuating, aggressive

Mind

Forgetful, difficulty learning new things, easily confused difficult
concentrating, easily frustrated, easily distracted, difficult to make
decisions, can't switch off, loss of interest in daily life, fogginess,
dyslexia, dyspraxia, 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, nausea, sensation of fullness
Acid reflux, heartburn, flatulence, belching, churning, painful,
irritable bowel syndrome, celiac, hiatus hernia, diverticula, polyps
haemorrhoids, ulcers, sluggish, sensitive, constipation, diarrhoea

Genitals

Itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis
pelvic inflammatory disease, impotence, painful intercourse, vaginal
dryness, painful or frequent 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 nails, burning
feet, tender heels, gout, sciatica, cold feet, tingling, numb, prickling

Important Symptoms:

Please indicate by underling if you suffer from any of the following symptoms which may require additional medical care:

Persistent or unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine, stools,
Breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite,
Paralysis, slurred speech, unexplained bruising, rash or weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy

Your vital statistics

- _____ What is your normal blood pressures?
- _____ Your resting pulse rate?
- _____ Your current weight?
- _____ Your height?
- _____ Your waist circumference? (if known)
- _____ Your hip circumference? (if known)
- _____ Your blood type?
- _____ Is your weight stable, increasing or decreasing
- _____ Did you have the normal immunisations as a child?

Your Family History

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc.) state disease, age at onset, gender

Grandparents: _____

Parents: _____

Siblings: _____

Your daily Life

- _____ Do you enjoy your daily life?
- _____ How many people depend on your support?
- _____ Do you feel supported by people around you?
- _____ Are you recently separated/divorced/a new partner?
- _____ Are you recently bereaved?
- _____ Have you moved house or changed jobs recently?
- _____ Do you work long or irregular hours?
- _____ Is your workload bigger than you can manage?
- _____ Are you under significant stress in any other way?
- _____ Do you feel guilty when you are relaxing?
- _____ Do you have a strong drive for Achievement?
- _____ Do you often do 2 or 3 tasks simultaneously?
- _____ Do you take regular exercise?
- _____ Is your job active?
- _____ Do you have any active hobbies?
- _____ Do you sleep well?
- _____ What do you do for relaxation?

Your digestion

Do you regularly experience....

- _____ Indigestion (after food or between meals)?
- _____ Indigestion after fatty food?
- _____ Bowel movement shortly after eating?
- _____ Frequent stomach upsets or stomach pain?
- _____ Nausea or vomiting?
- _____ Pain between the shoulders or under the ribs?
- _____ Constipation or hard-to-pass stools?
- _____ Diarrhoea or 'urgency to go'?
- _____ Blood or mucus in stools?
- _____ Undigested food in stools?
- _____ Generally inconsistent bowel movements?
- _____ Anal itching?
- _____ Thrush or cystitis?
- _____ How many bowel movements do you have in 24 hours
- _____ Have you noticed any recent change in bowel habit?
- _____ Are your stools pale, mid brown, dark brown, black, grey
- _____ Have you ever had a stomach upset after foreign travel?
- _____ Do any foods cause digestive problems? (which ones)

Your Toxic Exposure

- _____ Do you live, exercise or work in a city or by a busy road
- _____ Do you spend a lot of time on busy road?
- _____ Do you live close to an agricultural area?
- _____ Do you drink unfiltered water?
- _____ Do you drink alcohol? If so, how many units?
- _____ What is your normal alcoholic drink?
- _____ Do you smoke? If so, how many a day? _____
- _____ Do you live in a smoky atmosphere?
- _____ Do you think you may be addicted to anything?
- _____ Do you spend a lot of time in front of a TV or VDU?
- _____ Do you spend a lot of time on a mobile phone?
- _____ Do you sunbathe a lot?
- _____ Are you a frequent flyer?
- _____ Are you exposed to chemicals through a hobby?
- _____ Do you heat, freeze or wrap food in plastics?
- _____ Do you cook or wrap food in aluminium?
- _____ Do you regularly take antacid (indigestion) medication
- _____ Roughly what percentage of your food is organic?
- _____ Do you frequently fry or roast food at high temperatures?
- _____ Do you regularly eat browned or barbecued foods?
- _____ Do you eat oily fish or shellfish more than 3 x a week?
- _____ Do you regularly consume artificial sweeteners?
- _____ Do you floss your teeth regularly?
- _____ Are your teeth filled with mercury amalgams?

Your Energy Levels

- Do you need more than 8 hours sleep per night?
- Is your energy less than you want it to be?
- Do you find it difficult to get going in the morning?
- Do you feel drowsy during the day?
- What time(s) of day is your energy lowest?
- Do you get dizzy or irritable if you don't eat often?
- Do you use caffeine, sugar or nicotine to keep going?
- Do you find it difficult to concentrate?
- Do you feel dizzy or light-headed if you stand up quickly?
- Do you suffer from unexplained fatigue or listlessness?

Women Only

- Are you pregnant? If so how many weeks
- Are you trying to become pregnant?
- Are you breast-feeding at present?
- How many children have you had?
- Have you had problems with fertility?
- Have you ever had a miscarriage?
- What contraception do you use?
- Are you still menstruating?
- Are you or have you been on HRT?
- Are your periods regular?
- Any bleeding or spotting in between?
- Are your periods particularly heavy or painful?
- Do you suffer from PCOS, fibroids, endometriosis?
- Any known genito-urinary conditions?
- Are you happy with your sex drive?

Menstruating Women: please indicate by underlining if you experience: pre-menstrual, bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches, other?

Menopausal Women: please underline if you suffer from: Hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

Men only

- Do you experience mood swings or depression?
- Loss of sex drive?
- Loss of motivation
- Any known genito-urinary
- Fertility problems?
- Problems achieving or maintaining an erection?
- Frequent or difficult urination?
- Prostate problems?
- Wake at night to urinate?
- Difficult to start or stop urine stream?
- Pain or burning when urinating?

Eating Habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find hard to give up

Do you cater for a special diet in the household?

Who does the cooking in your household?

Do you avoid any food for cultural/ethical reasons?

Do you suspect any foods don't agree with you?

Have you recently changed your diet?

Do you eat on the move/when stressed?

Do you ever have eating binges?

What do you binge on?

Have you ever suffered from an eating disorder?

Do you chew your food thoroughly?

Are you excessively thirsty?

Please complete the separate food and lifestyle diary

Healthcare Providers

Is this your first visit to a Nutritional Therapist?

How did you find out about me?

GP's Name _____

Address _____

Phone Num _____

Are any other therapists/clinics involved in your care? Please list:

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

Signed _____