Nutritional Therapy Questionnaire

This information will be treated as strictly confidential

This questionnaire will help assess how Nutritional therapy can help you with your health problems. Please answer all the questions adding any additional information at the back. You do not need to answer the questions. ***All information shared is treated with strict confidentiality****.*

General Information

Name	**Mr Mrs Miss Dr Other**
Address	**Date of Consultation** **Telephone Number** **Mobile** **Email**

Date of Birth	**Marital Status**
Occupation	**Number of Children their age and gender**

Height **Weight** **Is your weight stable, increasing or decreasing?** ***BMI*** ***Hip: Waist Circumference***	**Current blood pressure (if known)** **Cholesterol level (if known)** **Have you had any blood tests recently? Why?** **Have you experienced any digestive disorder as a result of travelling abroad?**
Permission to contact your medical doctor? **Is your medical doctor aware of your intention to see a Nutritional Therapist?**	**Doctors name and address** **Telephone number**

Are you pregnant, planning to become pregnant or experiencing fertility problems at this time?

Health Profile

Please make a list of all the health concerns you would like to address, & indicate how long you have had these problems. E.g. Headaches, 5 years.

Health Concerns/Goals		**Duration**

What do you hope to achieve from the support of a Nutritional Therapist?

Have you any anxiety/fears or concerns about this lifestyle change?

What do you think has gotten in the way/is getting in the way for you so far to achieve your health goals?

Have you any ideas of what would make things easier for you that can help me to support you? Are you an all or nothing person or like small changes?

Do you have support from your partner, children, parents, and friends? (YES, some support, supportive but not like minded)

MEDICATION

Please list <u>all</u> medication you are <u>currently</u> taking and have taken in the <u>past</u> (remember to include the pill, antacids, painkillers, antibiotics, inhalers):			
Medication	**Prescribed by**	**Dosage / Frequency**	**Duration**

MEDICAL HISTORY

Please list your illnesses/operations (excluding colds and flu) starting from your childhood and including your present problems.

Your health history: illnesses and operations	Age of Onset	Duration	Related medication

If there is a family history of the following conditions please tick the appropriate box. Please add any other conditions if not included in the list

M= male F = female	Grandparents		Parents		Siblings		Cousins		Offspring	
	M	F	Male	Female	M	F	M	F	M	F
Heart Disease										
High Blood Pressure										
High cholesterol										
Osteoarthritis										
Rheumatoid arthritis										
Thyroid problems										
Osteoporosis										
Allergies										
Obesity										
Asthma										
Depression										
Alcoholism										
Cancer										
Type 1 Diabetes										
Type 2 Diabetes ('late onset')										

PAST LIFESTYLE

Were you breastfed?
Did you have all the childhood vaccinations?
Did you have regular childhood diseases such as measles, chickenpox etc.
What was your childhood diet like? Please give details
Would you consider yourself to have been a happy, active child?

SYSTEMS PROFILE

Please read the following list of symptoms and fill in the number that applies:
(How significant is the symptom? How true is the statement?)
KEY
0= No or do not have the symptom, the symptom does not occur
1= Yes or it is a minor or mild symptom or it rarely occurs (once a month or less)
2= It is a moderate symptom or it occasionally occurs
3= It is a major symptom or it frequently occurs daily

DIGESTIVE TRACT PROFILE

	Belching Have you been able to associate it with anything in particular and/or foods?
	Heartburn (burning pain behind breastbone). How soon after you eat?
	Acid Reflux. How soon after you eat?
	Use of antacids (ie *Rennies* or *Gaviscon*). If yes, how often?
	Bad Breath
	Coated tongue
	Frequent stomach upsets. Have you been able to associate it with any foods in particular? Is it stress related?
	Stomach upset by taking vitamins
	Stomach upset by greasy foods
	Feel like skipping breakfast
	Feel better if you don't eat
	Finger nails chip or break easily
	Bloating. What situations make it worse? Do any foods make it worse? Does anything make it better?
	Abdominal pains or cramps associated with excess gas
	Abdominal pains or cramps **not** associated with excess gas
	Diarrhoea
	Alternating constipation and diarrhoea
	How many bowl movements do you have per day? If you experience less than one bowel movement per day, how many per week?
	Black or tarry stools
	Undigested food in stools
	Light clay coloured stools
	Greasy or shiny stools
	Anus itching
	Known history of parasites, worms or bacterial infestations
	Blood in stool. How long has this been occurring?

	Mucous in stool. How long has this been occurring?
	Have you had any GIT investigations such as an endoscopy or colonoscopy? Please indicate

LIVER PROFILE

	Easily intoxicated by alcohol. How many units would it take for you to feel the effects of alcohol?
	Frequent nausea
	Tendency to motion sickness
	Bitter taste in mouth especially after meals
	Sensitive to perfume
	Strong reaction to caffeine such as palpations, feeling jittery or keeping you awake?
	Sweat has a strong odour
	Strong reaction to medication such as antibiotics or the pill
	Haemorrhoids
	Sensitive to tobacco smoke

ENDOCRINE (HORMONAL) SYSTEM

	Difficulty sleeping
	Require more than 8 hours sleep a night
	Hard to get going in the morning
	Need a stimulant e.g. coffee to get going in the morning
	Frequent fatigue
	A need for caffeine, sugar or cigarettes to keep you going during the day
	Frequent drowsiness during the day? Do think any foods make this worse? If yes, which foods. Do think any foods make this better? If yes, which foods.
	Dizziness or irritability if you don't eat often
	Frequent sweating
	Excessive thirst
	Loss of concentration and short attention span
	Poor memory or memory had deteriorated recently
	Reduced energy
	Tendency to depression or social isolation
	Intolerance to cold or heat
	Cold hands and feet
	Weight gain/difficulty losing weight
	Frequent headaches
	Rapid or irregular heartbeat
	Nervousness or anxiety
	Teeth-grinding
	Irritability
	Frequent migraines

IMMUNE PROFILE

	Runny or drippy nose. Do food and/or pollen that make this worse?
	Frequent infections/colds and flu's
	Frequent antibiotic use. How many courses have you taken?
	Frequent cystitis. If yes, how often?
	Frequent thrush. If yes, how often?
	Difficulty shaking off infections
	Never seem to get sick at all
	History of Epstein Bar, Herpes, shingles, Chronic fatigue, Hepatitis or other chronic viral conditions
	Inflammatory conditions. For example eczema, hayfever, asthma or arthritis. If yes, please name the condition/s
	Skin conditions such as eczema, acne or psoriasis. Do any situations or foods that make this worse?

Women Only

	Depression around period
	Irritability around period
	Tearfulness around period
	Chocolate craving around period
	Breast tenderness around period
	Excessive menstrual flow
	Blood clots in menstrual flow
	Variations in menstrual cycle
	Gains around hips, thighs and buttocks
	Excess facial hair
	Bloating or water retention around period
	Missed period

CARDIOVASCULAR PROFILE

	1 stone (7kg) above ideal weight
	Shortness of breath with moderate exertion
	Muscle cramps with exertion
	Unexplained facial flushing where the face turns red
	Fainting or feeling light headed
	Heart palpitation or missed heartbeat
	Dull pain or tightness in the chest
	Numbness or tingling in left arm
	"Air hunger" or sighing frequently
	Varicose Veins

MEN ONLY

	Prostate problems
	Difficult to stop or start urine stream
	Waking to urinate at night
	Feeling of incomplete bowel evacuation
	Decreased sexual function

LIFESTYLE PROFILE

Please answer the questions below as fully as possible to give us a clearer picture of your current lifestyle

SLEEP

How many hours sleep do you get on average per night?
On average, what time do you go to bed?
Does this feel like enough?
Do you have difficulty falling asleep?
Do you wake in the night on a regular basis?
Do you wake feeling refreshed?

EXERCISE

How much exercise do you do a week? Please give details
Is your job stationary or active? Give details
Do you have any active or physically tiring hobbies? E.g. gardening Running
Do you consider yourself to be fit?

STRESS

Are you prone to getting easily impatient?
Do you find it hard to say no to people?
Do you tend to bottle up your feelings?
Do you find it difficult to relax or guilty when you relax and do nothing?
Do you have problems organising yourself/and or others?
Are there currently any long-term stressful situations in your life? Please give details if you are comfortable doing so. **On a scale of 0 –10, 0 having no stress and 10 being extremely stressed, how would you rate your current stress level?**
Have there been long-term stressful situations in your past such as bereavement, separation, unemployment or career change or change of home location? Please give details if you are comfortable doing so
In times of stress, do you have a strong support network? (Friends, family, and/or community)

ENVIRONMENTAL FACTORS

Are you exposed to a lot of pollution?
Do you smoke or are there smokers in your home?
How many amalgam (silver) fillings do you have?
Have you ever taken recreational drugs? If so when and how often?
Do you work with or have regular contact with any chemical substances e.g. paints, solvents, dry cleaning fluid, pesticides?

DIETARY PROFILE – also see food checklist attached

EATING HABITS

In your household who does the majority of the cooking? **Do you enjoy cooking?**
Do you avoid any foods/food groups for medical reasons?
How would you describe your appetite?
Do you ever eat simply because you are depressed and/or anxious?
Do you ever eat simply because you are bored?
Do you often eat under stressful conditions or on the move?
Do you eat out a lot? How often?
How often do you eat take–away food? What type?
How many units of alcohol do you drink per week on average (one unit = a 125ml glass of wine, ½ a pint of beer or lager, a 25ml unit of spirits)?

Foods that you particularly like	Foods that you particularly dislike

Please list any supplements (including protein powders/sports supplements) that you are currently taking or have taken in the past. Please give details. It would be helpful to bring these to the consultation or list the brand name

Do you diet often? What diets have worked for you in the past? Please give details.
Please write down all the foods and drinks consumed over a 3-day period (it is advisable to include 1 weekend day), and the approximate times that they were consumed. Please also include your daily routine. For example what time you get up at, where and when you first eat etc.

Day 1
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks **Were you feeling stressed at any stage while eating today?** **Any physical Activity today?**

Day 2
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks **Were you feeling stressed at any stage while eating today?** **Any physical Activity today?**
Day 3
Breakfast What time did you get up? When and where did you have your breakfast? What did you eat and drink?
Lunch When and where? What did you eat and drink?
Dinner When and where? What did you eat and drink?
Drinks and snacks **Were you feeling stressed at any stage while eating today?** **Any physical Activity today?**

Are there any foods or drinks that you consume regularly that did not appear in the food diary?

Are these days above typical or unusual days for you?

Please write any additional information here