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_____Sex_____Marital Status_____

Address_____

Postcode_____Email_____

Phone Numbers_____Occupation_____

Health Profile

What is your main reason for seeking nutritional advice?_____

What outcome are you hoping to achieve?_____

Please list the health problems you would like to focus on.

Health Problem (eg. Arthritis)	**Management so far (eg. GP, operation, tests, drugs)**	**Onset (Date)**	**Duration**
1.			
2.			
3.			
4.			
5.			

Have you had any recent health tests (eg. Blood tests, scans, allergy tests etc.)? Please specify or attach if appropriate_____

Have you had any major surgery, biopsies, diagnosed medical conditions, significant periods of ill health, or do you suffer from any chronic or niggling health problems (other than those above)? (please give details eg. High blood pressure, frequent colds, recurring infections etc.)_____

_____

_____

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

Medication and Supplements

Please list anything your take regularly including GP prescribed medication, self-prescribed medication, nutritional supplements, herbal or homeopathic remedies.

Remedy	Dose	Condition being treated	Frequency & Duration
1.			
2.			
3.			
4.			
Antibiotic History: please state when you last took antibiotics plus any previous times you can remember:			

Your Family History

Please list any illnesses, conditions or allergies that your family members have experienced (eg. Heart disease, diabetes, allergies, asthma, cancer etc.). Please state disease, age of onset etc.

Mother	Father
Brother	Sister
Maternal Grandmother	Maternal Grandfather
Paternal Grandmother	Paternal Grandfather
Children	

Vital Statistics

_____What is your normal blood pressure?

_____Your current weight

_____Your height

_____Your waist circumference

_____Your hip circumference

_____Your blood type (if known)

_____Is your weight stable?

_____Did you have normal immunisations?

Toxic Exposure

_____Do you live or work in a City?

_____Do you live close to an agricultural area?

_____Do you drink unfiltered water?

_____How many units of alcohol a week?

_____What is your normal alcoholic drink?

_____Do you smoke? How many a day?

_____Are you a frequent flyer?

_____Do you have any mercury fillings?

_____Do you cook or wrap food in foil?

_____Do you heat or wrap food in plastics?

_____Are you exposed to chemicals at work?

_____Do you use a microwave regularly?

_____Do you fry or BBQ regularly?

_____Do you steam or boil vegetables?

Digestion - Do you regularly experience…

_____ Indigestion

_____Bowel movement shortly after eating

_____Frequent stomach upsets or pain

_____Nausea or vomiting

_____Constipation or hard to pass stools

_____Diarrhoea or ‘urgent to go’

_____Blood or mucus in stools

_____Undigested food in stools

_____Bloating after meals

_____Inconsistent bowel movements

_____How many bowel movements a day

_____Any recent changes in bowel habit

_____Heartburn

_____Have you travelled recently?

_____Do any foods cause digestive upset?

_____Which foods?

_____How often do you urinate?

_____What colour yellow is your urine?

_____Is your need to urinate urgent?

_____Thrush or cystitis?

_____Do you eat when stressed?

_____Do you eat at regular times each day?

_____Are you vegetarian/vegan?

Daily Life

_____Do you enjoy daily life?

_____How many people depend on you?

_____Do you feel supported by those around?

_____Are you recently separated/divorced?

_____Are you recently bereaved?

_____Have you moved house or job recently?

_____Do you work long/irregular hours?

_____Do you feel under significant stress?

_____Do you feel guilty when relaxing?

_____Do you have a strong drive to achieve?

_____Do you take regular exercise?

_____What do you do to relax?

_____Is your job active?

Women Only

_____Are you pregnant? How many weeks?

_____Are you trying to become pregnant?

_____How many children have you had?

_____Have you had problems with fertility?

_____Are you on contraception? Which?

_____Are you still menstruating?

_____Are you/have you been on HRT?

_____Are your periods regular? Cycle length?

_____Any bleeding or spotting in between?

_____ Are you periods heavy or painful?

_____Any clotting?

_____Do you suffer from PCOS, fibroids?

_____Are you happy with your sex drive?

Energy Levels

_____How many hours sleep do you need?

_____How many hours sleep do you get?

_____ Is your energy less than you want?

_____Do you feel refreshed on waking?

_____Do you feel drowsy in the day?

_____What time(s) is your lowest energy?

_____Do you get irritable if you don't eat?

_____Do you use caffeine to keep going?

_____Do you find it hard to concentrate?

_____Do you feel dizzy on standing?

_____Do you sleep well?

_____Do you find it hard to get to sleep?

_____Do you wake in the night?

Men Only

_____Do you wake at night to urinate?

_____Pain or burning on urination?

_____Difficulty starting or stopping urine?

_____Do you experience mood swings?

_____Any known genito-urinary conditions

_____Do you have a loss of sex drive?

_____Loss of motivation or drive?

_____Fertility problems?

Eating habits

Do you cater for a special diet in house? _____

Who does the cooking in the house?_____

Do you avoid any foods for cultural/ethical reasons?_____

Do you suspect any foods disagree with you?_____

Do you eat on the move or when stressed?_____

Do you have eating binges? If so what on?_____

Are you a fast eater?_____

Are you excessively thirsty? How much do you drink?_____

Have you ever suffered from an eating disorder?_____

Which are your favourite foods? _____

Which foods do you dislike?_____

Which foods do you crave?_____

Which foods would you find it hard to give up?_____

How motivated are you to change your diet/lifestyle? Not at all 1 2 3 4 5 6 7 8 9 10 Very

Health Care Providers

Is this your first visit to a Nutritional Therapist?_____

How did you find out about me?_____

GP's Name _____Phone_____

GP's Address:_____

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 health professionals where appropriate.

Signed_____ Date_____

3 Day Lifestyle Diary

Name:

Your diet – Please record your food intake across 2 fairly typical work days and 1 weekend/day off. Please give as much information as possible: home cooked or not, brand names, fresh, packaged, whole, refined, organic etc.

	Weekday 1 – Date	**Weekday 2 - Date**	**Day off - Date**
Breakfast	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snacks	Time:	Time:	Time:
Drinks			

Your Routine

Name:

Please provide as much information as possible about your daily routine for the same 3 days.

	Weekday 1 – Date	**Weekday 2 - Date**	**Day off - Date**
Wake up time			
Get up time			
Work day start time			
Work day end time			
Do you break for lunch?			
Time spent travelling			
Time spent exercising			
Type of exercise			
Exercise time of day			
Time spent relaxing			
Type of relaxation			
Other leisure activity			
Other routine……			
Energy low times			
Overall mood			
Go to Bed time			
Fall asleep time			
Uninterrupted sleep	Y/N	Y/N	Y/N
Other relevant			