NUTRITIONAL THERAPY QUESTIONNAIRE

This information will be treated as strictly confidential.

Please answer questions as accurately as you can. The information you give will help your treatment.
There are no "right" or "wrong" answers. Please write clearly.

GENERAL INFORMATION

Name:	Title:
Address:	Tel.No
	Mobile
	E-mail:
	Date of Birth:
Height:	Weight:
Occupation:	Details of any dependants: (inc. age)

REASONS FOR MAKING A NUTRITION APPOINTMENT

Please list the main health areas you would like to address.
1.
2.
3.

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.

MEDICAL HISTORY

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)

Please specify any regular medication you may be taking: (*ie: aspirin, HRT, painkillers, contraceptive pill etc)*

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

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)

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

LIFESTYLE

Would you describe yourself as: Sedentary ☐ Moderately active ☐ Active ☐ Very active☐

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?

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 ☐

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

123**SECTION 1**123**SECTION 9** Poor memoryNausea or vomitingConfusion, poor comprehensionDiarrhoeaPoor concentrationConstipationPoor physical co-ordinationBloated feelingDifficulty making decisionsBelching, or passing windAre any of the above made worse by skipping a mealHeartburn123**SECTION 2**123**SECTION 10** HeadacheAcneFaintness or dizzinessHives, rash or dry skinInsomniaHair lossFlushing or hot flushes123**SECTION 3**Excessive sweatingWatery or itchy eyesSoft, fraying or brittle nailsSwollen, reddened, sticky eyelidsSensitive to bright light123**SECTION 11** Blurred or tunnel vision (does not include near or far sight)Water retentionBinge eating or drinking123**SECTION 4**Cravings for certain foodsItchy earsLack of appetiteEaraches, ear infectionCompulsive eatingDischarge from earRinging in ears, hearing loss123**SECTION 12** Frequent illness123**SECTION 5**Frequent or urgent urinationStuffy nose or Sinus problemsGeneral itch or dischargeHay feverExcessive thirstExcessive mucus formationLoss of taste or smellSensitive to strong smells e.g. perfume, petrol etc123**SECTION 13 female only**123**SECTION 6**Menstrual painChronic coughTender/painful breastsGaggingMood change before periodFrequent need to clear throatSore throat, hoarseness, loss of voice123**SECTION 14 male only**Sore tongueDifficulty urinatingProne to cold soresLoss of libidoMood changes123**SECTION 7**Irregular or skipped heartbeat123**SECTION 15** Rapid or pounding heartbeatMood swingsChest painAnxiety, fear or nervousnessAnger, irritability, aggressiveness123**SECTION 8**DepressionChest congestion/ wheezingAsthma123**SECTION 16** Shortness of breathFatigue, sluggishnessDifficulty breathingApathy, lethargyHyperactivityRestlessness

Other symptoms: (not mentioned above including sleep patterns)

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. Please also note any exercise taken.

Put down approximate portion sizes and any physical symptoms you felt during the day.

Date:		**Food and Drink consumed**	
Time	**Quantity:**		**Symptom:**
Date:		**Food and Drink consumed**	
Time:	**Quantity:**		**Symptom:**
Date:		**Food and Drink consumed**	

Time:	Quantity:		Symptom:

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.

I appreciate that nutritional therapy is a means of helping the body heal itself through natural means. I understand that nutritional therapy does not diagnose medical conditions, although it can in some cases help manage them.
Nutritional therapy is not a substitute for professional medical treatment.

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