PRIVATE AND CONFIDENTIAL *(This information will not be disclosed to third parties)*

Nutritional Assessment Questionnaire

Title _____ First name _____ Last name _____ Date of birth _____

Address _____

Post code _____ email _____ Phone _____

Occupation _____ Weight _____ Height _____ Age _____

Part 1 Health Profile

Please list the health issues you would like to focus on:

Health issue (eg arthritis, weight)	Onset/duration
1.	
2.	
3.	
4.	
5.	

What outcome are you hoping to achieve? _____

Have you had any recent health tests, surgery, biopsies, diagnosed medical conditions, significant periods of ill health or suffer from any allergies, chronic or niggling health problems? *(please give details)* _____

_____

_____

Medications and remedies *(please list anything you take regularly including GP prescribed medication, self-prescribed medication (eg painkillers), nutritional supplements, herbal or homeopathic remedies)*

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)*			

Your GP's name _____ Address _____

Are there any other therapists/clinics involved in your care? _____

Heredity profile

Do you have children? _____ Do they suffer any particular illness? _____

What illnesses is/was your father prone to? _____

What illnesses is/was you mother prone to? _____

What illnesses are/were your siblings prone to? _____

What illnesses are/were your grandparents prone to? _____

Lifestyle

Do you enjoy your daily life? _____

How much time do you spend outdoors? _____ Do you regularly expose your skin to sunlight? _____

Do you sleep well? _____ How many hours sleep do you usually get? _____

Do you take regular exercise? _____ What kind of exercise? _____

Is your job active? _____ Do you have any active hobbies? _____

What do you do for relaxation? _____

What is your normal blood pressure? *(don't worry if you don't know)* _____

Toxic exposure

Do you live, exercise, work or spend a lot of time near busy roads? _____

Do you live close to an agricultural area? _____

Are you a frequent flyer? _____

Are you exposed to chemicals through work or hobby? _____

Do you smoke? If so, how many a day? _____ Do you live in a smoky atmosphere? _____

Do you drink alcohol? If so, how many units a week? _____What is your normal alcoholic drink? _____

Are your teeth filled with mercury amalgams? _____

Do you spend a lot of time in front of a TV/VDU? _____

Do you spend a lot of time on a mobile phone? _____

Do you heat, freeze or wrap food in plastics? _____

Do you cook or wrap food in aluminium? _____

Do you regularly eat browned or barbequed foods? _____

Do you frequently fry or roast food at high temperatures? _____

Do you regularly consume artificial sweeteners? _____

Roughly what percentage of your food is organic? _____

Do you think you may be addicted to anything? _____

Stress levels

Are you recently separated/divorced/a new parent? _____ Are you recently bereaved? _____

Have you moved house or changed jobs recently? _____

Do you work long or irregular hours? _____

Are you under any other significant stress? _____

Do you have a strong drive for achievement? _____

Do you feel guilty when relaxing? _____

Do you feel supported by people around you? _____

Do you easily become angry? _____

Diet *Please also complete the separate food and lifestyle diary*

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 avoid any foods for cultural/ethical reasons? _____

Are you allergic/intolerant to any foods? _____

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

Have you recently changed your diet? _____

Have you ever suffered from an eating disorder? _____

Do you ever have eating binges? _____ What do you binge on? _____

Do you cater for a special diet in the household? _____

Who does the cooking in your household? _____

Do you chew your food thoroughly? _____

Do you eat on the move/when stressed? _____

Are you excessively thirsty? _____

What are your usual drinks? _____

What water do you drink? (eg. filtered, tap, bottled in plastic, bottled in glass) _____

Was your childhood/teen diet healthy? _____

Were you breastfed as a baby? _____

Were you born by caesarean section? _____

Part 2

Please tick all the symptoms that you are experiencing:

Section 1 – Upper Gastrointestinal System			
Belching or gas within 1 hour of a meal		Do you feel like skipping breakfast?	
Heartburn or acid reflux		Do you feel better if you don't eat?	
Bloating shortly after eating		Do you feel sleepy after meals?	
Bad breath (halitosis)		Fingernails chip, peel or break easily	
Loss of taste for meat		Anaemia unresponsive to iron	
Sweat has a strong odour		Stomach pains or cramps	
Stomach upset by taking vitamins		Diarrhoea, chronic	
Sense of fullness after meals		Diarrhoea shortly after meals	
Undigested food in stools		Black or tarry stools	
Hurried eating habits			

Section 2 – Liver and Gallbladder			
Pain between shoulder blades		Gallbladder removed?	
Stomach upset by greasy foods		Become sick if drinking wine	
Greasy or shiny stools		If drinking alcohol, easily intoxicated	
Light or clay-coloured stools		Hangovers after drinking alcohol	
Nausea		History of hepatitis	
History of morning sickness		History of drug or alcohol overuse	
Dry skin		Long-term use of prescription medications	
Itchy feet and/or skin peels on feet		Sensitive to chemicals (perfumes, cleaning solvents, exhaust, insecticides, tobacco smoke etc)	
Headache over the eye		Pain under right side of rib cage	
Bitter taste in mouth, especially after meals		Chronic fatigue or fibromyalgia	

Section 3 – Small intestine			
Food allergies		Alternating constipation and diarrhoea	
Abdominal bloating 1-2 hours after eating		Feel spacey or unreal	
Specific foods make you tired or bloated		Are there foods you could not give up?	
Pulse speeds up after eating		Asthma, sinus infections, stuffy nose	
Airborne allergies (eg hay fever)		Bizarre, vivid or nightmarish dreams	
Suffer from hives		Use over-the-counter pain medications	

Section 4 – Large intestine			
Anus itches		Less than 1 bowel movement per day	
Coated tongue		Stools are loose or not well formed	
Feel worse in musty or mouldy atmosphere		Irritable bowel or mucus colitis	
Fungus or yeast infections (eg athletes foot, thrush)		Blood in stool	
Stools hard or difficult to pass		Mucus in stool	
History of parasite infection		Excessive foul smelling lower bowel gas	
Dark circles under eyes		Bad breath or strong body odours	
Cramping in lower abdominal region			

Section 5 – Vitamin & Mineral Needs			
Muscles become easily fatigued		Pale skin	
Feel worse, sore after moderate exercise		Tendency to anaemia	
Vulnerable to insect bites		Easily exhausted	
Worrier, apprehensive, nervous		Teeth grinding	
Depressed		Wake up without remembering dreams	
Crave chocolate		Sore tongue	
Muscle cramps		Sensitive to strong light at night	
White spots on fingernails		Bleeding gums, especially when brushing teeth	
Nosebleeds or tend to bruise easily		Cold sores or herpes lesions	
Restless legs		Frequent skin rashes or hives	
Decreased sense of taste or smell		Lump in throat	
Slow wound healing and/or scar easily		Difficulty swallowing	
Strong foot odour		Small bumps on back of arms	
Bone loss (osteoporosis or osteopenia)		Take contraceptive pill	
Tooth decay		Poor night vision	
Mouth ulcers		Muscle twitches	

Section 6 – Essential Fatty Acids			
Low or reduced fat diet (past or present)		Headaches when out in the hot sun	
Crave fatty or greasy foods		Sunburn easily	
Tension headaches at base of skull		Dry flaky skin and/or dandruff	
Suffer from PMS/PMT		Dry eyes	
History of infertility		Excessive thirst or sweating	
Poor memory and concentration			

Section 7 – Sugar Handling			
Awaken a few hours after falling asleep, hard to get back to sleep		Fatigue that is relieved by eating	
Crave sweets		Headache if meals are skipped or delayed	
Eat desserts or sugary snacks		Irritable before meals	
Binge or uncontrolled eating		Shaky if meals delayed	
Excessive appetite		Family members with diabetes	
Crave coffee or sugar in the afternoon		Frequent thirst	
Sleepy in the afternoon		Frequent urination	
Skin tags			

Section 8 – Adrenal			
Tend to be a ‘night person’		Crave salty foods	
Difficulty falling asleep		Perspire easily	
Slow starter in the morning		Chronic fatigue, or get drowsy often	
Need more than 8 hours sleep		Use caffeine, sugar or nicotine to keep going	
Keyed up, trouble calming down		Afternoon yawning	
Feeling wired or jittery if drinking coffee		Afternoon headache	
Clench or grind teeth		Allergies and/or hives	
Calm on the outside, troubled inside		Dizzy when standing up suddenly	
Chronic low back pain, worse with fatigue		Difficulty concentrating	

Section 9 – Thyroid			
Allergic to iodine		Difficulty losing weight	
Difficulty gaining weight, even with large appetite		Sensitive to cold, poor circulation (cold hands and feet)	
Nervous, emotional, can't work under pressure		Easily fatigued, sleepy during the day	
Inward trembling		Constipation – chronic	
Flush easily		Mentally sluggish, reduced initiative	
Fast pulse at rest		Excessive hair loss and/or coarse hair	
Intolerance to high temperatures		Morning headaches, wear off during the day	
Seasonal sadness		Loss of outer third of eyebrow	

Section 10 – Immune system			
Runny or drippy nose		Itchy skin or dermatitis	
Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc)		History of Epstein Barr, Mono, Herpes, Shingles, Chronic fatigue, Hepatitis or other viral infection (*please underline those applicable)*	
Frequent colds or flu		Acne (adult)	
Mucus producing cough		Cysts, boils, rashes	

Section 11 – Men only			
Prostate problems		Loss of sex drive	
Urination difficult or dribbling		Decreased sexual function	
Difficult to start and stop urine stream		Problems achieving or maintaining an erection	
Waking regularly to urinate at night		Fertility problems	
Pain or burning with urination		Chronic constipation	
Mood swings or depression			

Section 12 – Women only			
Are you pregnant? If so, how many weeks?		Loss of sex drive	
Are you breastfeeding?		PCOS, Endometriosis, fibroids	
How many children have you had?		Breast fibroids, benign masses	
Have you had problems with fertility?		Painful intercourse	
Have you ever had a miscarriage?		Vaginal discharge	
Are you still menstruating?		Vaginal dryness	
Depression during periods		Vaginal itchiness	
Heavy or painful periods		Gain weight around hips, thighs and buttocks	
Irregular menstrual cycles		Excess facial or body hair	
Menopausal hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness, other? *(please underline all that apply)*		Pre-menstrual bloating, tiredness, irritability, mood swings, breast tenderness, water retention, headaches, crave chocolate *(please underline all that apply)*	