NUTRITION PROGRAMME QUESTIONNAIRE

PRIVATE AND CONFIDENTIAL

This questionnaire is designed to provide your nutritionist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First name: **Last name:**

Address:

Post code: **E-mail:**

Telephone number: (Work) (Home)

Occupation: **Date of birth:**

Your weight (without clothes): **Your height** (without shoes):

GP Details:

Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems e.g. Headaches 5 years (Continue on a separate sheet if you need more space)

	Health Problem	**Duration**
1		
2		
3		
4		
5		
6		

What medication (drugs) **do you take for these** (state daily dosage)

Under what circumstances do these problems improve?

Under what circumstances do they get worse?

What other illnesses have you had in the past ten years?

What operations have you had?

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

Have you had a major life trauma (please give the date(s))

Heredity Profile

Do you have any children? If so, state age and sex.

Are there any particular illnesses your siblings suffer from?

How many brothers and sisters do you have? State age and sex.

What illness is/was your father prone to?

Do You have amalgam fillings?

What illness is/was your mother prone to?

SYMPTOM ANALYSIS

This section lists symptoms associated with particular nutritional deficiencies. Tick the conditions you suffer from. You can select conditions by pointing and clicking with your mouse over the grey tick boxes. Some symptoms are repeated. Please tick them in all cases.

Mouth ulcers
Poor night vision
Acne
Frequent colds or infections
Dry flaky skin
Dandruff
Thrush or cystitis
Diarrhoea

Rheumatism or arthritis
Back ache
Tooth decay
Hair loss
Excessive sweating
Muscle cramps, or spasms
Joint pain or stiffness
Lack of energy

Lack of sex drive
Exhaustion after light exercise
Easy bruising
Slow wound healing
Varicose veins
Loss of muscle tone
Infertility

Frequent colds
Lack of energy
Frequent infections
Bleeding or tender gums
Easy bruising
Nose bleeds
Slow wound healing
Red pimples on skin

Tender muscles
Eye pain
Irritability
Poor concentration
'Prickly' legs
Poor memory
Stomach pains
Constipation
Tingling hands
Rapid heart beat

Burning or gritty eyes
Sensitivity to bright lights
Sore tongue
Cataracts
Dull or oily hair
Eczema or dermatitis
Split nails
Cracked lips

Lack of energy
Diarrhoea
Insomnia
Headaches or migraines
Poor memory

Muscle tremors or cramps
Apathy
Poor concentration
Burning feet or tender heels
Nausea or vomiting
Lack of energy
Exhaustion after light exercise
Anxiety or tension
Teeth grinding

Infrequent dream recall
Water retention
Tingling hands
Depression or nervousness
Irritability
Muscle tremors or cramps
Lack of energy
Flaky skin

Poor hair condition
Eczema or dermatitis
Mouth over sensitive to hot or cold
Irritability
Anxiety or tension
Lack of energy
Constipation
Tender or sore muscles
Pale skin

Eczema
Cracked lips
Prematurely greying hair
Anxiety or tension
Poor memory
Lack of energy
Poor appetite
Stomach pains
Depression

Dry skin
Poor hair condition
Prematurely greying hair
Tender or sore muscles
Poor appetite or nausea
Eczema or dermatitis

Dry, rough skin
Dry eyes
Frequent infections
Poor memory
Loss of hair or dandruff
Excessive thirst
Poor wound healing
PMS or breast pain
Infertility

Muscle cramps or tremors
Insomnia or nervousness
Joint pain or arthritis
Tooth decay

Muscle tremors or spasms
Muscle weakness
Insomnia or nervousness
High blood pressure
Irregular heart beat
Constipation
Fits or convulsions
Hyperactivity
Depression

Pale skin
Sore tongue
Fatigue or listlessness
Loss of appetite or nausea
Heavy periods or blood loss

Poor sense of taste or smell
White marks on more than two finger nails
Frequent infections
Stretch marks
Acne or greasy skin
Low fertility
Pale skin
Tendency to depression
Poor appetite

Muscle twitches
Childhood 'growing pains'
Dizziness or poor sense of balance
Fits or convulsions
Sore knees

Family history of cancer
Signs or premature ageing
Cataracts
High blood pressure
Frequent infections

Excessive or cold sweats
Dizziness or irritability after 6 hours without food
Need for frequent meals
Cold hands
Need for excessive sleep or drowsiness during the day
Excessive thirst
'Addicted' to sweet foods

Anxiety or tension ☐
Depression ☐
Irritability ☐
Bleeding or tender gums ☐
Acne ☐

High blood pressure ☐

LIFESTYLE ANALYSIS

Please answer 'Yes' or 'No' to the questions below.

Cardiovascular Profile

_____ Is your blood pressure above 140/90?
_____ Is your pulse after 15 minutes rest above 75?
_____ Are you more than 14lbs (7kg) over your ideal weight?
_____ Do you smoke more than 5 cigarettes a day?
_____ Do you do less than two hours exercise a week?
_____ Do you eat more than one spoon of sugar a day?
_____ Do you eat meat more than 5 times a week?
_____ Do you usually add salt to your food?
_____ Do you have more than 2 alcoholic drinks a day?
_____ Is there a history of heart disease in your family?

Exercise Profile

_____ Do you take exercise that noticeably raises your heart beat for 20 minutes more than 3 times a week?
_____ Does your job involve vigorous activity?
_____ Do you regularly play a sport? *(football, squash etc.)*
_____ Do you have any physically tiring hobbies? *(gardening etc.)*
_____ Do you consider yourself fit?

Pollution Risk Profile

_____ Do you live in a city or by a busy road?
_____ Do you spend more than 2 hours a week in traffic?
_____ Do you exercise (jog, cycle, play sports) by busy roads?
_____ Do you smoke more than 5 cigarettes a day?
_____ Do you live or work in a smoky atmosphere?
_____ Do you buy foods exposed to exhaust fumes?
_____ Do you generally eat non-organic produce?
_____ Do you drink more than 1 unit or oz of alcohol a day? *(1 glass wine, 1 pint of beer, or 1 measure of spirits)*
_____ Do you spend a lot of time in front of a TV or VDU?
_____ Do you usually drink unfiltered tap water?

Stress Profile

_____ Is your energy less now than it used to be?
_____ Do you feel guilty when relaxing?
_____ Do you have a persistent need for achievement?
_____ Are you unclear about your goals in life?
_____ Are you especially competitive?
_____ Do you work harder than most people?
_____ Do you easily become angry?
_____ Do you often do 2 or 3 tasks simultaneously?
_____ Do you get impatient if people or things hold you up?
_____ Do you have difficulty getting to sleep?

Glucose Tolerance Profile

_____ Do you need more than 8 hours sleep a night?
_____ Are you rarely wide awake within 20 minutes of rising?
_____ Do you need something to get you going in the morning, like tea, coffee or a cigarette?
_____ Do you have tea, coffee, sugar containing foods or drinks, or cigarettes, at regular intervals during the day?
_____ Do you often feel drowsy during the day?
_____ Do you get dizzy or irritable if you don't eat often?
_____ Do you avoid exercise due to tiredness?
_____ Do you sweat a lot or get excessively thirsty?
_____ Do you sometimes lose concentration?
_____ Is your energy less now than it used to be?

Digestive Profile

_____ Do you chew your food thoroughly?
_____ Do you sometimes suffer from bad breath?
_____ Are you prone to stomach upsets?
_____ Do you often get a burning sensation in your stomach?
_____ Do you find it difficult digesting fatty foods?
_____ Do you occasionally use indigestion tablets?
_____ Do you suffer from flatulence or bloating?
_____ Do you experience anal irritation?
_____ Do you have a bowel movement daily?

Immune Profile

_____ Do you get more than three colds a year?
_____ Do you find it hard to shift an infection (cold or otherwise)?
_____ Are you prone to thrush or cystitis?
_____ Do you often take antibiotics more than twice a year?
_____ Is there a history of cancer in your family?
_____ Have you ever had any growths or lumps biopsied?
_____ Do you have any inflammatory conditions such as eczema, asthma, hay fever or arthritis?
_____ Have you suffered from a childhood trauma?
_____ Do you suffer from allergy problems?
_____ Have you had a major personal loss in the last year?

Histamine Profile

Tick the following the apply to you:

☐ Sleep over 8 hours	☐ Little sex drive
☐ Much body hair	☐ Infrequent colds
☐ Sluggish metabolism	☐ Slow to wake up
☐ Short toes and fingers	☐ Suspicious by nature
☐ Fat or 'well covered'	☐ Can tolerate pain
☐ Sleep less than 7 hours	☐ Strong sex drive
☐ Little body hair	☐ Family history of allergies
☐ Fast metabolism	☐ 'Morning person'
☐ Long toes and fingers	☐ Tends towards depression
☐ Don't put on weight	☐ Poor tolerance of pain

Allergy Profile

Do you suffer from any of the following? Please tick

☐ Nasal problems	☐ Migraine
☐ Hay fever	☐ Irritable bowel syndrome
☐ Eczema	☐ Frequent bloatedness
☐ Dermatitis	☐ Facial puffiness
☐ Asthma	

Do you have any allergies? _____
If so, what? _____
State type of reaction? _____
Have you been tested? _____
What food or drinks would you find hard to give up?

_____

Additional questions for Women Only

_____ Are you pregnant? If so, how many weeks? _____
_____ Are you trying to become pregnant?
_____ Have you ever had a miscarriage?
_____ Do you have an IUD fitted, or use the birth control pill?
State which? _____
_____ Are your periods regular?
_____ Are you post-menopausal?

Do you suffer from any pre-menstrual symptoms? (tick which ones)

☐ Bloatedness	☐ Tiredness

Irritability

Depression

Breast tenderness

Headaches

DIET ANALYSIS

Please answer 'Yes' or 'No' or indicate number of times you eat the food referred to in the question.

1. _____ Were you breast fed?
2. _____ Was a significant percentage of your diet as a child high in fatty foods and sugar?
3. _____ Do you go out of your way to avoid foods containing preservatives or additives?
4. _____ Do you avoid foods which contain sugar?
5. _____ How many teaspoons or sugar do you add to food/drinks each day?
6. _____ Do you use salt in your cooking?
7. _____ Do you add salt to your food?
8. _____ How many coffees do you drink each day?
9. _____ How many cups of tea do you drink each day?
10. _____ How many times a week do you have meals containing deep-fried food?
11. _____ How many packets of 'instant' or fast foods do you eat each week?
12. _____ How many times a week do you eat chocolate or confectionery?
13. _____ What percentage of your diet is **raw** fruit and **raw** vegetables?
14. _____ Do you wash fruit and vegetables before eating?
15. _____ Do you normally eat white rice or flour?
16. _____ How many cans of food do you eat per week?
17. _____ How many slices or bread or rolls do you eat each week?
18. _____ How many pints of milk do you drink in a week?
19. _____ How many times a week do you eat red meat? *(beef, pork, lamb or game)*
20. _____ How many times a week do you eat white meat? *(poultry, fish)*
21. What is your usual alcoholic drink? _____
22. _____ How many glasses do you drink a week?
23. _____ How many times a week do you eat live yoghurt?
24. _____ Do you use a water filter or drink bottled water instead of tap water?
25. _____ Do you frequently eat under stressful conditions or on the move?
26. _____ Does your job involve eating out a lot?
27. How would you describe your appetite?

☐ Poor ☐ Average ☐ Good

Write down all the foods and drinks consumed over the next 3 days, or the last 3 days. Please add as much information as possible including quantities eaten, brand names, and whether the food is fresh or packaged, refined or natural.

Day 1

Breakfast (include time eaten)

Lunch (include time eaten)

Dinner (include time eaten)

Snacks/Drinks

Day 2

Breakfast (include time eaten)

Lunch (include time eaten)

Dinner (include time eaten)

Snacks/Drinks

If the above do not reflect your usual diet, please record a typical day below.

Breakfast

Lunch

Dinner

Snacks/Drinks

What nutritional supplements do you take daily on a regular basis?

I hereby confirm that this information is correct to the best of my knowledge and that I am not withholding any important information. I understand that a 24 hours cancellation period is required to avoid a cancellation fee.

Name: Date: