

helen@nutritionalwellness.co.uk

Tel: 07786 926638

**Nutritional Therapy Health and Dietary Questionnaire**

All information given will be treated as strictly confidential

Date completed:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Personal Details | | | | | | | | | | | |
| Name: |  | | | | | DOB: |  | | | | |
| Address: | | |  | | | Home phone: | | | |  | |
| Mobile: | |  | | | |
| Email: |  | | | | |
| Postcode: | | |  | | |  | | | | | |
| Height: | |  | | | | Weight: | |  | | | |
| Marital status: | | | | |  | Occupation: | | |  | | |
| Drs name: | | |  | | | Permission to contact Dr? | | | | |  |
| Drs address: | | | |  | |  | | | | | |

What is your main reason for seeking nutritional advice?

|  |
| --- |
|  |

When did the problem first start and what has been the duration? What are the main symptoms? Please give as much detail as possible.

|  |
| --- |
|  |

What outcome are you hoping to achieve?

|  |
| --- |
|  |

**Current health**

Please list your main health concerns in order of priority including how long you have experience the problem and any medication you have taken to treat it.

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Concern** | **Onset** | **Duration** | **Medication** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Are there any medications or supplements that you are currently taking or have taken over a length of time or have had to take repeatedly? Please include any over the counter medications such as aspirin, anti-histamines etc

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of medication / supplement (please include brand name)** | **Year started** | **Reason for taking** | **Duration and dosage** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

|  |
| --- |
|  |

Do you think your symptoms might be due to a particular event in your life?

|  |
| --- |
|  |

Have you had any health tests?

|  |
| --- |
|  |

From childhood to current date, please list any major surgery, accidents, biopsies, diagnosed medical conditions, periods of ill health, chronic health problems. Please give details (eg frequent colds, urinary tract infections, thrush, stress, bereavement, high blood pressure)

|  |  |
| --- | --- |
| Dates | Description |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Family history**

Please list any notable illnesses or conditions that your family members have experienced (eg diabetes, heart disease, cancer, arthritis, asthma, eczema). Where possible please include age of onset.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Mother | | Maternal Grandmother | | |
|  | |  | | |
| Maternal Grandfather | | |
|  | | |
| Father | | Paternal Grandmother | | |
|  | |  | | |
| Paternal Grandfather | | |
|  | | |
| Siblings | | | | |
|  | | | | |
| Digestion: do you suffer from any of the following on a regular basis. Please tick or \* | | | | **Energy levels** |  | |
| Abdominal bloating 1 to 2 hrs after eating | |  | | How many hrs sleep per night? |  | |
| Nausea | |  | | What time do you go to bed/wake up? |  | |
| Heartburn | |  | | Do you feel refreshed when you wake? |  | |
| Acid reflux | |  | | Do you wake up in the night? |  | |
| Frequent burbing | |  | | Do you have trouble getting to sleep? |  | |
| Excessive flatulence | |  | | Do you constantly feel tired? |  | |
| Stomach or abdomen distension | |  | | Do you feel tired at certain times during the day? At what time(s)? |  | |
| Use of antacid | |  | | Do you use caffeine, sugar or tobacco to keep going? |  | |
| Dark circles under eyes | |  | | Do you find it difficult to concentrate? |  | |
| Asthma, sinus infections, stuffy nose | |  | | Do you feel dizzy or irritable if you do not eat regularly? |  | |
| **Urination** | | | | **Bowel health** |  | |
| How many times a day? | |  | | How many bowel movements per day /per week (please put both) |  | |
| Colour – light/dark | |  | | Do you suffer from constipation? |  | |
| Do you need to go in the night? | |  | | Do you strain? |  | |
| Any pain or burning? | |  | | What colour are your stools? |  | |
| Noticeable smell? | |  | | Is there blood/mucus in your stools? (state which) |  | |
| Do you feel thirsty regularly? | |  | | Have you suffered from recurrent diarrhoea? |  | |
| Is your thirst quenched when you drink? | |  | | Undigested food in stools? |  | |
| Previous urinary infections? | |  | |  |  | |
| **Pregnancy & childbirth** | | | | | | |
| Number of full term pregnancies | |  | | Have you had any miscarriages? |  | |
| Any drugs given, forceps used etc? | |  | | What contraception do you use? |  | |
| Any Caesareans? | |  | | Have you had any fertility problems? |  | |
| Did you breast feed, for how long? | |  | | Are you trying to get pregnant? |  | |
| Are your periods regular? | |  | | Have you had complications in pregnancy or with the delivery? |  | |
| How long is your cycle? | |  | | Have you had IUI or IVF treatment? Dates: |  | |
| Have you had an abnormal smear result? | |  | | Are you taking HRT? |  | |
| **PCOS/Endometriosis** | | | | | | |
| Do you have painful or heavy periods | |  | | Do you have pain during sexual intercourse? |  | |
| Do you have pain in the lower abdomen (tummy), pelvis or lower back? | |  | | Do you have bleeding between periods |  | |
| Do you have discomfort when urinating ? | |  | | Do you have bleeding from your back passage? |  | |
| Do you have acne? | |  | | Do you have abnormal hair growth? |  | |
| Do you have male pattern baldness? | |  | | Do you have brown skin patches? |  | |
| Do you have weight gain on hips, thighs, stomach? | |  | |  |  | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **LIFESTYLE PLEASE TICK OR \* ANY OF THE FOLLOWING THAT APPLY TO YOU:** | | | | | | |
| Changed jobs within the last 6 months? | |  | | | Job involves working with chemicals |  |
| Ended a long term relationship within the last year | |  | | | Drink more than 1 unit of alcohol /day (1 glass of wine, 1 pint of beer or 1 measure of spirit) |  |
| Tend to work more than 60 hours/week | |  | | | Generally eat non-organic food |  |
| Live in a city or by a busy road | |  | | | Spend a lot of time in front of a tv or computer |  |
| Exercise (jog/cycle/sports) by busy roads | |  | | | Usually drink unfiltered tap water |  |
| Smoke cigarettes | |  | | | Eat processed food 3/week or more |  |
| Regularly use drugs (medicinal and/or recreational) | |  | | | Mercury fillings recently removed |  |
| **BODY SYTEMS: PLEASE TICK or \* ANY OF THE FOLLOWING THAT APPLY TO YOU:**  **Gastric** | | | | | |
| Belching or gas within 1 hr of a meal |  | | History of antacids or PPI medication | | ­­­­ |
| Heartburn or acid reflux |  | | Do you feel better if you don’t eat? | |  |
| Bloating shortly after eating |  | | Constipation/needing to strain | |  |
| Dietary supplements cause nausea |  | | Bright red blood spots on loo paper | |  |
| Prone to gastritis or gastric ulcers |  | | Diarrhoea, chronic | |  |
| Do not chew food properly – eat in a hurry |  | | Black or tarry stools | |  |
| Sense of excess fullness after meals |  | | Undigested food in stools | |  |
| **Microbiota** | | | | | |
| Abdominal bloating 1 to 2 hrs after eating |  | | Crohn’s disease or ulcerative colitis | |  |
| Fatigue after meals |  | | Churning feeling in the GI tract | |  |
| Odorous flatulence |  | | Lower abdominal pain from trapped wind | |  |
| Alternating constipation and diarrhoea |  | | Current or previous antibiotics | |  |
| Gastro-enteritis while abroad |  | | Eating fruit causes bloating | |  |
| Current or previous parasitic infection |  | | Feel spacey or unreal: ‘brain fog’ | |  |
| Have had IBS symptoms after foreign travel |  | | Crave bread or other starchy or sugary foods | |  |
|  |  | | Fungal skin or nail infection | |  |
| **INTESTINAL MEMBRANE** | | | | | |
| Known or suspected food sensitivities. Please list: |  | Are there any foods you could not give up? Please list: | | |  |
| Diagnosed auto-immune illness |  | ­Stools hard or difficult to pass | | |  |
| History of antibiotics, indigestion medication or NSAIDs (ibuprofen or aspirin) |  | Irritable bowel symptoms | | |  |
| Asthma/sinusitis or other GI infection |  | Mucus in stool | | |  |
| Less than one bowel movement per day |  | Unexplained muscle aches | | |  |
| Unexplained stiff joints or pains in joints |  |  | | |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Hepatic biotransformation & biliary** | | | | | | | | |
| Pain between shoulder blades |  | | | | Number of alcoholic drinks per week |  | | |
| Stomach upset by greasy foods |  | | | | Hangovers after drinking alcohol |  | | |
| Greasy or shiny stools |  | | | | History of drug or alcohol abuse |  | | |
| Nausea |  | | | | History of hepatitis |  | | |
| Stools hard and/or difficult to pass |  | | | | Long term use of prescription medicines |  | | |
| Headache over the eye |  | | | | Sensitive to chemicals (perfume, exhaust, |  | | |
| Gallbladder attacks (past or present) |  | | | | Pain under right side of rib cage |  | | |
| Gallbladder removed |  | | | | Haemorrhoids or varicose veins |  | | |
| Become sick if drinking wine |  | | | | Unexplained fatigue |  | | |
|  |  | | | | Diet High in sugar/fructose |  | | |
| **Glucose Tolerance** | | | | | | | | |
| Awaken a few hours after falling asleep, hard to get back to sleep |  | | Fatigue that is relieved by eating | | | |  | |
| Crave sweets, starches or stimulants |  | | Headache, irritable or shakiness if meals are skipped or delayed | | | |  | |
| Eat desserts or sugary snacks |  | | Family members with diabetes | | | |  | |
| Binge or uncontrolled eating |  | | Frequent thirst | | | |  | |
| Excessive appetite |  | | Frequent urination | | | |  | |
| Sleepy in afternoon |  | | Unintended weight loss or weight gain | | | |  | |
| **HPA Axis** | | | | | | | | |
| Tend to be a "night person" |  | | Low mood/anxiety | | | |  | |
| Difficulty falling asleep |  | | Crave salty foods | | | |  | |
| Rarely wide awake within 30 mins or rising |  | | Unable to deal with stress | | | |  | |
| Keyed up, trouble calming down |  | | Often tearful | | | |  | |
| High blood pressure (normal 120/80) |  | | Chronic fatigue, or get drowsy often | | | |  | |
| Headache after exercising |  | | Fatigued after exercise | | | |  | |
| Feeling wired or jittery if drinking coffee |  | | Feel run down or overwhelmed | | | |  | |
| Clench or grind teeth |  | | Afternoon headache | | | |  | |
| Become dizzy when standing up suddenly |  | | Feel physically weak | | | |  | |
| **HPT Axis** | | | | | | | | |
| Difficulty losing weight |  | | Mentally sluggish, reduced initiative | | | | |  |
| Unexplained depression, difficulty coping |  | | Easily fatigued, sleepy during the day | | | | |  |
| Carpal tunnel symptoms |  | | Sensitive to cold, poor circulation (cold hands & feet) | | | | |  |
| Morning headaches, wear off during the day |  | | Constipation, chronic | | | | |  |
| Loss of lateral 1/3 of eyebrow |  | | Excessive hair loss and / or coarse hair | | | | |  |
| Low mood in winter |  | |  | | | | |  |
| **HPO Axis** | | | | | | | | |
| PMS: anxiety, irritability, tension, mood swings |  | | Breast fibroids, benign masses | | | | |  |
| PMS: craving chocolate, fatigue, headaches |  | | Painful intercourse (dyspareunia) | | | | |  |
| PMS: breast tenderness, bloating, water retention, weight gain |  | | Vaginal itchiness and/or discharge | | | | |  |
| PMS: depression, crying, forgetfulness |  | | Vaginal dryness | | | | |  |
| Excessive menstrual flow |  | | Excess facial or body hair | | | | |  |
| Occasional skipped periods |  | | Diagnosed polycystic ovarian syndrome | | | | |  |
| Variations in menstrual cycles |  | | Menopausal, peri- or post-menopausal | | | | |  |
| Endometriosis |  | | Hot flushes | | | | |  |
| Decreased sex drive |  | | Headaches (especially premenstrually) | | | | |  |
| Uterine fibroids |  | | Night sweats (in menopausal females) | | | | |  |
| PCOS |  | | Thinning skin | | | | |  |
| **Cardiovascular** | | | | | | | | |
| Personal/family history of high blood pressure, high cholesterol or cardiovascular disease |  | | Ankles swell, especially at end of day | | | | |  |
| Aware of heavy and / or irregular breathing |  | | Exercise less than 30 mins X 3/week | | | | |  |
| Smoke cigarettes |  | | Is your pulse after 15 mins rest, > 75? | | | | |  |
| Overweight |  | | Dull pain or tightness in chest and / or radiate into right arm, worse with exertion | | | | |  |
| "Air hunger" and / or yawn frequently |  | | Muscle cramps with exertion | | | | |  |
| Shortness of breath with moderate exertion |  | |  | | | | |  |
| **Immune System** | | | | | | | | |
| Runny or drippy nose | |  | | Not breast fed as a baby | | | |  |
| Itchy or watery eyes | |  | | Itchy skin / skin rash | | | |  |
| Mucus-producing cough | |  | | Prone to cysts or boils | | | |  |
| Frequent thrush, cystitis, or infections of the | |  | | History of Epstein Bar, Herpes, Shingles, | | | |  |
| ears, sinuses, lung, skin, bladder, or kidney) | |  | | Hepatitis or other chronic viral condition | | | |  |
| Frequent colds or flu (> 4/year) | |  | | General malaise, fatigue, slow thinking, apathy | | | |  |
| Prone to cold sores | |  | | Swollen lymph nodes | | | |  |
| Known or suspected allergies of food | |  | | Unexplained joint/muscular aches and pains | | | |  |
| sensitivities | |  | | Antibiotics > twice a year | | | |  |
| Excessive sneezing | |  | | Do you have an inflammatory condition, e.g.,eczema, asthma or an auto-immune disease? | | | |  |
| Eating specific foods causes bloating, fatigue or | |  | | Personal or family history of cancer | | | |  |
| Neurotransmitters | | | | | | | | |
| Low mood | |  | | Inability to concentrate /lack of focus | | | |  |
| Sugar/starch cravings | |  | | Hyperactivity | | | |  |
| Pain syndromes, e.g., migraine, fibromyalgia | |  | | Addictions | | | |  |
| Poor sleep | |  | | Apathy/life is a drag | | | |  |
| Mitochondria | | | | | | | | |
| Fatigue | |  | | Ticked many boxes in Liver section | | | |  |
| Diagnosed cardiovascular disease and/or  periodontal (gum) disease | |  | | Do not eat nuts, seeds and green leafy  vegetables every day | | | |  |
| Ticked many boxes in Toxic Exposure section | |  | | Do not eat raw fruit and vegetables every day | | | |  |
| Take statin medication | |  | | Muscular aches and pains | | | |  |

**Micronutrient Analysis**

Each question in this section starts with a list of symptoms associated with nutritional insufficiency.

*Underline or highlight the conditions you often suffer from. Some symptoms are repeated. Please underline them in all cases.*

|  |  |  |  |
| --- | --- | --- | --- |
| Ulcers: gastric/mouth  Poor night vision  Acne  Frequent colds or infections  Dry flaky skin  Thrush or cystitis  Diarrhoea | Inflammation  Back ache  Tooth decay  Cardiovascular disease  Overweight  Muscle weakness  Joint pain or stiffness  Low bone density | Low sex drive  Age spots  Cataracts  Cardiovascular disease  Premature ageing  Infertility | Frequent colds  Lack of energy  Frequent infections  Bleeding or tender gums  Easy bruising  Nose bleeds  Slow wound healing  Broken capillaries  Varicose veins |
| Numbness in legs  Burning feet or hands  Fatigue  Pins and needles  Headaches  Poor memory/concentration  Stomach pains  Sleep disturbance  Cracked lips | Burning or gritty eyes  Sensitivity to bright lights  Sore tongue  Mouth cracks (corners)  Dull or oily hair  Eczema or dermatitis  Split nails  Dry, peeling, cracked lips | Lack of energy  Diarrhoea  Dermatitis  Headaches or migraines  Poor memory  Anxiety or tension  Depression  Irritability  High cholesterol  Raynaud’s disease | Poor stress tolerance  Stressful lifestyle  Apathy  Poor concentration  Numbness in the feet  Lack of energy  Exhaustion after light exercise  Anxiety or tension  Teeth grinding |
| Infrequent dream recall  Water retention  Tingling hands  Depression or nervousness  Mood swings or irritability  PMS  Cardiovascular disease  Flaky skin or dermatitis | Weakness  Mouth sensitive to hot or  cold  Irritability or moodiness  Anxiety or tension  Lack of energy  Constipation  Smooth, sore tongue  Tingling in hands/feet  Poor memory  Pale skin | Cardiovascular disease  Pale skin  Fatigue  Shortness of breath  Cracked lips  Anxiety or tension  Poor memory  Lack of energy  Regular alcohol use  Depression | Dry skin  Poor hair condition  Fungal/yeast infections  Excessive hair loss  Eczema or dermatitis |
| Dry, rough skin  Inflammation  Elevated triglycerides  Cardiac problems  Dry flaky skin  Excessive thirst  Poor wound healing  PMS or breast pain  Depression | Muscle cramps or tremors  Insomnia or nervousness  Tooth decay  Low bone density | Muscle tremors or spasms  PMS  Migraine  Insomnia or nervousness  High blood pressure  Irregular heart beat  Constipation  Fits or convulsions | Pale skin  Sore tongue  Fatigue or listlessness  Breathlessness  Hair loss  Heavy periods or blood loss |
| Poor sense of taste or smell  White marks on finger nails  Frequent infections  Stretch marks  Acne or greasy skin  Low fertility  Pale skin  Tendency to depression  Poor appetite | Family history of cancer  Signs of premature ageing  Cataracts  High blood pressure  Frequent infections  Mercury fillings | Excessive or cold sweats  Dizziness or irritability  after 6 hours without food  Need for frequent meals  Drowsiness during the day  ‘Addicted’ to sweet foods  or stimulants | White coating on tongue  Fungal nails  Thrush (historically or currently) |

**Dietary History**

|  |
| --- |
| Do you have any dietary restrictions? |

|  |
| --- |
| Are you allergic/intolerant of any foods? Please list: |

Have you been tested for these allergies? Please list method of testing and known results

|  |  |  |
| --- | --- | --- |
| Year | Test | Result |
|  |  |  |

Please tick cooking methods generally used:

Boiling  Steam  Grilling  Deepfry

Shallow fry  Bake  Roast  Microwave

|  |
| --- |
| What type of fat do you usually use in cooking? Please list all used. |
|  |
| What are your favourite foods? |
| Are there any foods that you would find it difficult to live without? |
| Are there any foods that you crave? |
| What foods do you particularly dislike? |
| Do you eat when stressed? If so what foods? |
| How many units of alcohol do you drink a week and what type? |
| Do you exercise? How many times a week, duration and what type? |

Are you vegan?  Yes  No

Are you vegetarian?  Yes  No

**4 Day Food Diary**

Please complete a 4 day food diary, including at least one weekend day. Please give as much detail as possible, listing all food, drink and snacks that you have throughout the day from when you get up until you go to sleep. State what time you ate the food or had the drink and if the food is homemade, fresh, whole, organic, take away, in a restaurant to help with the assessment. For drinks please also state the time, number of drinks and how much; if you have milk in your tea/coffee and how many sugars, if you drink green tea or herbal tea, carbonated drinks (sugar free or normal etc), how much water, fruit juice etc and units/type of alcohol.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Time | Weekday | Weekday | Weekday | Weekend |
| Morning |  |  |  |  |  |
| Lunch |  |  |  |  |  |
| Afternoon |  |  |  |  |  |
| Evening |  |  |  |  |  |