

Nutritional Therapy Questionnaire

PRIVATE AND CONFIDENTIAL

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

CLIENT DETAILS

First Name Last Name

Address
 Post Code

Telephone: (Eve (Day)

Mob: E.Mail

Occupation .DOB

GP's Name / Address / Tel:

Height: Weight: Blood group(if known

Blood pressure Do you smoke if yes how many/day

Alcohol intake Yes No Units per day .Units per week

Do you have amalgam fillings (if yes how many)

Have you had root canal work or other major dental work (Please detail)

Current problem

Have you consulted your doctor? Yes / No

Attitude to Orthodox v Alternative medicine

Understanding of Wholistic Nutritional Medicine

HEALTH PROFILE

Please list any health problems you would like to clear up and indicate how long you have had these problems e.g.: migraine headaches 2 years. Continue on a separate piece of paper if you need more space)

	Name	How many yrs
1.		
2.		
3.		
4.		
5.		
6.		

What medications (drugs) do you take for these? (state daily dose)

Under what circumstances do these problems improve or get worse (state which)

What operations have you had?

Do you have a motion daily? (if not explain – if yes give description of stools)

Patient's view of his/her disease:

Please give any further information that may be helpful

REST OF MEDICAL HISTORY

Babyhood

Pre-school years

School & teenage years

Adult history

FAMILY HISTORY

PARENTS

Mother

Father

GRANDPARENTS

Maternal

Paternal

BROTHERS & SISTERS

AUNTS, UNCLAS, COUSINS ETC.

LIFESTYLE ANALYSIS

Please list all the foods and drink that is consumed over the two day period – with times.
Give an idea of quantities and whether it was fast food or fresh

DAY 1	DAY 2
Breakfast - time	Breakfast - time
Lunch - time	Lunch - time
Evening meal - time	Evening meal - time
Snacks and drinks - time	Snacks and drinks - time

What would you say was your most problem food/s?

Indicate what exercise you take over the day

Do you take any vitamin/mineral supplements? (if so please list)

Times in your life when diet has changed drastically and how?

MEDICAL SYMPTOMS ANALYSIS

Rate each of the following symptoms based upon your typical health profile for the past 30 days

Point scale 0 - Never or almost never have the symptoms
 1 – Occasionally have it, the effect is not severe
 2 - Occasionally have it, the effect is severe
 3 – Frequently have it, effect is not severe
 4- – Frequently have it, effect is severe

HEAD	<input style="width: 30px; height: 40px;" type="text"/>	Headaches Faintness Dizziness Insomnia	Total	<input style="width: 100px; height: 20px;" type="text"/>
EYES	<input style="width: 30px; height: 40px;" type="text"/>	Watery or itchy eyes Swollen, reddened or sticky eyelids Bags or dark circles under eyes Blurred or tunnel vision	Total	<input style="width: 100px; height: 20px;" type="text"/>
EARS	<input style="width: 30px; height: 40px;" type="text"/>	Itchy ears Ear aches, ear infections Drainage from ears	Total	<input style="width: 100px; height: 20px;" type="text"/>
NOSE	<input style="width: 30px; height: 40px;" type="text"/>	Ringing in ears, hearing loss Stuffy nose Sinus Problems Hay fever Sneezing attacks Excessive mucous formation	Total	<input style="width: 100px; height: 20px;" type="text"/>
MOUTH/THROAT	<input style="width: 30px; height: 40px;" type="text"/>	Chronic coughing Gagging, frequent need to clear throat Sore throat, hoarseness, loss of voice swollen or discoloured tongue, gums lips Canker sores	Total	<input style="width: 100px; height: 20px;" type="text"/>
SKIN	<input style="width: 30px; height: 40px;" type="text"/>	Acne Hives, rashes, dry skin Hair loss Flushing, hot flushes Excessive sweating	Total	<input style="width: 100px; height: 20px;" type="text"/>
HEART	<input style="width: 30px; height: 40px;" type="text"/>	Irregular or skipped heart beat Rapid or pounding heartbeat Chest pain Chest congestion Asthma, bronchitis Shortness of breath Difficulty breathing	Total	<input style="width: 100px; height: 20px;" type="text"/>
DIGESTIVE TRACT	<input style="width: 30px; height: 40px;" type="text"/>	Nausea, vomiting Diarrhoea Constipation Bloating feeling Belching, passing wind Heartburn, reflux Intestinal/stomach pain	Total	<input style="width: 100px; height: 20px;" type="text"/>

MUSCLE	<input type="text"/>	Pains or aches in joints Arthritis Stiffness or limitation of movement Pains or aches in muscles Feeling of weakness or tiredness	Total	<input type="text"/>
WEIGHT	<input type="text"/>	Binge eating/drinking Craving certain foods Excessive weight Compulsive eating Water retention Underweight	Total	<input type="text"/>
ENERGY/ ACTIVITY	<input type="text"/>	Fatigue, sluggishness Apathy, lethargy Hyperactivity Restlessness	Total	<input type="text"/>
MIND	<input type="text"/>	Poor memory Confusion, poor comprehension Poor Concentration Poor physical co-ordination Difficulty in making decisions Stuttering or stammering Slurred speech Learning disabilities	Total	<input type="text"/>
EMOTIONS	<input type="text"/>	Mood swings Anxiety, fear, nervousness Anger, irritability, aggressiveness Depression	Total	<input type="text"/>
OTHER	<input type="text"/>	Frequent illness Frequent or urgent urination General itching or discharge	Total	<input type="text"/>
			GRAND TOTAL	<input type="text"/>

OTHER INFORMATION

On a separate sheet of paper give any other information that you feel could be helpful.