Private & Confidential

Nutritional Questionnaire

Date of 1st Appointment	Please return completed form to
	Nutriology 3 Morland Drive Lamberhurst Kent TN3 8HZ 01892 891379 Lisa@nutriology.co.uk

CONTACT DETAILS

First Name:	Last Name:	Salutation:
Address: Post Code:		
Tel No: (Home)	Tel No: (Work)	
Mobile	E-mail address:	
Date of Birth:	Occupation:	
Age:	Height:	Weight:

HEALTH INFORMATION

Main Health Problem:
OTHER HEALTH PROBLEMS
Please list below the areas of your health which you would also like us to focus on or that you have suffered with in the past. Please give an indication of how long you have had these problems. Please list them in order of importance to you.
1.
2.
3
4
GP's Name and Address (optional)

MEDICAL HISTORY

What drugs or medications do you take at the moment? (please state the daily dosage and length of time you have been taking them)
Have you had any tests undertaken in respect of your current condition? If yes, please give details and, if available, please provide a copy of the results.

MEDICAL HISTORY / CONTD.

What drugs or medications have you taken in the past
Have you had any operations? If so, please give details and the date
Under what conditions do your current health problems get worse?
Under what conditions do your current health problems improve?
What other illnesses have you had in the past?

FAMILY HISTORY

If you have any children, please give their age and sex
How many siblings(brothers and sisters) do you have? (please give ages and sex)
Do your siblings have any illnesses? If so, please give details
How old is your father? How old is your mother? (If deceased, at what age did they pass away and what was the cause of death)
What illness is/was your father prone to?
What illness is/was your mother prone to?

Write down all the foods and drinks consumed over the next two days starting today. 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	DAY 2
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks	Snacks
Drinks	Drinks

Lifestyle & Dietary Analysis

Please answer the following questions. (Y=Yes N=No)

STRESS PROFILE

Question	
Is your energy less than it used to be?	Y/N
Do you feel guilty when relaxing?	Y/N
Do you go to bed tired and	Y/N
Do you wake up awake (Are you a morning person?)	Y/N
Do you have persistent need for achievement?	Y/N
Are you unclear about your goals in life?	Y/N
Are you especially competitive?	Y/N
Do you work harder than most people?	Y/N
Do you easily become angry?	Y/N
Do you often do 2 or 3 tasks simultaneously?	Y/N
Do you get impatient if people hold you up?	Y/N
Have you recently split up from a long term partner?	Y/N
Have you had a major personal loss / illness in the last 2 years?	Y/N

DIETARY PROFILE

Question	
How many days a week do you eat fresh fruit and vegetables?	
How many times a week do you eat red meat? (lamb, pork, beef, bacon, ham, sausages etc)	
How many times a week do you eat white meat? (chicken, turkey)	
How many times a week do you eat fish?	
How many times a week do you eat cheese?	
How many pints of milk do you drink in a week?	
How many slices of bread or rolls do you eat each week?	
Do you normally eat White bread / N / White rice / N / White pasta /	
How many times a week do you eat deep fried food?	
How many times a week do you eat fast food/takeaway?	
How many times a week do you eat ready-made meals?	
Do you add salt to your cooking?	
Do you add salt to your food?	
How many times a week do you eat chocolate, biscuits, cakes or	
Do you avoid foods containing preservatives / additives?	
Do you avoid foods that contain sugar?	
How many teaspoons of sugar do you add to your food or drinks each day?	
Do you use artificial sweeteners?	
How many cups of coffee do you drink each day?	
How many cups of tea do you drink each day?	
How many cans of fizzy drinks do you drink a week?	
How many units of alcohol do you drink a week?	
How many glasses of water do you drink a day?	
Do you use filtered or bottled water instead of tap water?	
Do you frequently eat under stressful conditions or on the move?	Y/N
Does your job involve you eating out a lot?	Y/N
How would you describe your appetite? Poor / Average / Good	

POLLUTION RISK PROFILE

Question	
Do you live in a city or by a busy road?	Y/N
Do you spend 2 hours a week or more in traffic?	Y/N
Do you exercise by a busy road?	Y/N
Do you smoke?	Y/N
Do you work or live in a smoky atmosphere?	Y/N
Does your work entail handling toxic substances such as herbicides or chemicals?	Y/N
Do you spend much time in front of a VDU?	Y/N

EXERCISE PROFILE

Question	
Do you take regular exercise?	Y/N
If so, how many times a week?	Y/N
Does your job involve vigorous activity?	Y/N
Do you have any physically tiring hobbies?	Y/N
Do you consider yourself fit?	Y/N

DIGESTION PROFILE

Question	
Do you chew your food thoroughly?	Y/N
Do you sometimes have bad breath?	Y/N
Are you prone to stomach upsets?	Y/N
Do you often get a burning feeling in your stomach?	Y/N
Do you have difficulty digesting fatty foods?	Y/N
Do you occasionally use indigestion tablets?	Y/N
Do you suffer from flatulence or bloating?	Y/N
Do you suffer with anal irritation?	Y/N
Do you have bowel movement daily?	Y/N

ADDITIONAL QUESTIONS FOR WOMEN ONLY

Question	
Are you pregnant?	Y/N
If so, how many weeks?	
Are you trying to become pregnant?	Y/N
Have you ever had a miscarriage?	Y/N
Do you have an IUD fitted?	Y/N
Do you use the birth control pill?	Y/N
Do you use another method of contraception?	Y/N
If so, please state	
Are your periods regular?	Y/N
Do you suffer with PMS?	Y/N
If so, do you suffer with any of the following:- Pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, headaches (underline all that apply)	
Are you peri or post menopausal?	Y/N
If so, do you suffer with any of the following:- Hot flushes, night sweats, aching joints, mood swings, poor memory, dry skin (underline all that apply)	

General Symptom & Health Analysis

Please answer the following questions (Y=Yes N=No)

BLOOD SUGAR PROFILE

Question	
Do you need more than 8 hours sleep a night?	Y/N
Do you find it hard to wake up in the morning?	Y/N
Do you miss meals on a regular basis?	Y/N
Do you drink coffee or tea throughout the day?	Y/N
Do you feel drowsy during the day?	Y/N
Do you get dizzy and irritable if you do not eat?	Y/N
Do you exercise a lot?	Y/N
Do you sweat or get very thirsty?	Y/N
Do you lose concentration or feel forgetful?	Y/N
Do you crave sweet foods or sweet drinks?	Y/N
Is your energy less than it used to be?	Y/N

IMMUNE PROFILE

Question	
Do you get more than 3 colds a year?	Y/N
Do you find it hard to shift an infection?	Y/N
Are you prone to thrush or cystitis?	Y/N
Do you often take antibiotics more than twice a year?	Y/N
Is there a history of cancer in your family?	Y/N
Have you ever had any growths or lumps biopsied?	Y/N
Do you suffer eczema, asthma or hayfever?	Y/N
Do you have any auto-immune conditions?	Y/N
Do you suffer from hay fever?	Y/N
Do you suffer from allergy problems?	Y/N
Have you had a major personal loss in the last year?	Y/N
Do you have a history of antibiotic use?	Y/N

JOINTS & MUSCLES PROFILE

Question	
Do you suffer from swollen joints?	Y/N
Do you suffer from muscle fatigue?	Y/N
Have you been diagnosed with fibromyalgia?	Y/N
Have you been diagnosed with arthritis?	Y/N
Do you have restricted movement of joints?	Y/N
Do you suffer from pins and needles?	Y/N
Do you suffer from muscle cramps or spasms?	Y/N
Do you suffer from restless legs?	Y/N
Do you take regular exercise?	Y/N
Do you have a physical disability of any kind?	Y/N
Do you have itchy legs or dry flaky skin?	Y/N

HEART & CIRCULATION PROFILE

Question	
Is your blood pressure over 140/90?	Y/N
At rest, is your pulse over 75?	Y/N
Are you more than 14lbs (7kg) over your ideal weight?	Y/N
Do you smoke? (If yes, how many…………………………….)	Y/N
Do you do less than 2 hours exercise a week?	Y/N
Do you have high cholesterol?	Y/N
Do you eat meat more than 5 times a week?	Y/N
Do you usually add salt to your food?	Y/N
Do you have more than 2 alcoholic drinks a day?	Y/N
Is there a history of heart disease in your family?	Y/N

EMOTIONAL HEALTH

Question		Question	
Do you suffer from depression?	Y/N	Do you suffer from anxiety?	Y/N
Is your depression and anxiety related to your menstrual cycle?	Y/N	Do you suffer from insomnia?	Y/N
Do you suffer from panic attacks?	Y/N	Do you ever feel tearful?	Y/N
		If so when?	

ANY OTHER RELEVANT INFORMATION