**PRIVATE AND CONFIDENTIAL**

# Nutrition Programme Questionnaire

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

**Mr/Ms/Miss/Mrs First Name:** _____ **Last Name:** _____

**Address:** _____

_____

**Post Code:** _____ **Email:**_____

**Telephone Number: (Work)** _____ **(Home)** _____

**Occupation:** _____ **Age:** _____ **Blood Group** (if known)**:**_____

**What is: Your Weight** (without clothes)**:** _____ **stone** _____**lbs Your Height** (without shoes)**:** _____ **feet**_____**inches**

## 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 medications** (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) _____

**What is your resting pulse rate per minute?** _____
(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

## Heredity Profile

**Do you have any children? Yes / No If so, state age and sex.**_____
**Are there any particular illnesses that they suffer from?**

_____

**How many brothers and sisters do you have?** _____ **State age and sex** _____
**Are there any particular illnesses that they suffer from?**

_____

**What illness is/was your father prone to?**

_____

**What illness is/was your mother prone to?**

_____

# SYMPTOM ANALYSIS

**Each question in this section starts with a list of symptoms associated with nutritional deficiency. Underline the conditions you OFTEN suffer from. Some symptoms are repeated. Please underline 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 pains
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
Anxiety or tension
Depression
Irritability
Bleeding or tender gums
Acne

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**
**High blood pressure**

**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 2 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 of premature ageing**
**Cataracts**
**High blood pressure**
**Frequent infections**

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

# LIFESTYLE ANALYSIS

| Cardiovascular Profile | Yes | No |
|---|---|---|
| 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 | Yes | No |
|---|---|---|
| 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 | Yes | No |
|---|---|---|
| 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 of 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 | Yes | No |
|---|---|---|
| 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 in getting to sleep? | ☐ | ☐ |

| Glucose Tolerance Profile | Yes | No |
|---|---|---|
| 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 a tea, coffee or 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? | ☐ | ☐ |

| Digestion Profile | Yes | No |
|---|---|---|
| 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? | ☐ | ☐ |
| Do your stools float? | ☐ | ☐ |

| Immune Profile | Yes | No |
|---|---|---|
| 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 an inflammatory disease such as eczema, asthma or arthritis? | ☐ | ☐ |
| Do you suffer from hayfever? | ☐ | ☐ |
| Do you suffer from allergy problems? | ☐ | ☐ |
| Have you had a major personal loss in the last year? | ☐ | ☐ |

**Histamine Profile** Tick all of the following that apply to you

Sleep over 8 hours ☐ Slow to wake up ☐ Little sex drive ☐
Much body hair ☐ Infrequent colds ☐ Sluggish metabolism ☐
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 ☐
'Morning person' ☐ Long toes and fingers ☐ Fast metabolism ☐
Tend towards depression ☐ Don't put on weight ☐
Poor tolerance of pain ☐ Family history of allergies ☐

**Allergy Profile** Tick all of the following that apply to you

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

Do you have any allergies? Yes ☐ No ☐ If so what? _____

_____

State type/s of reaction?_____
Have they been tested? _____
What food or drinks would you find hard to give up? _____

_____

| Additional Questions for WOMEN ONLY | Yes | No |
|---|---|---|
| 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? | ☐ | ☐ |
| Do you use the birth control pill? | ☐ | ☐ |
| Are your periods regular? | ☐ | ☐ |
| Are you post-menopausal? | ☐ | ☐ |

Do you suffer from any of the following pre-menstrual problems?
Tick all of the following that apply to you

Bloatedness ☐ Tiredness ☐ Irritability ☐ Depression ☐
Breast tenderness ☐ Headaches ☐

# DIET ANALYSIS

**Please tick only the questions to which you would answer 'Yes'. Also please fill in the 'number of times' you eat or drink the food referred to in the questions with blank spaces.**

| | | Yes |
|---|---|---|
| **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**. | Do you use salt in your cooking? | ☐ |
| **6**. | Do you add salt to your food? | ☐ |
| **7**. | How many teaspoons of sugar do you add to food/drinks each day? | _____ |
| **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 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**. | Do you use a water filter or drink bottled water instead of tap water? | ☐ |
| **17**. | Do you frequently eat under stressful conditions or on the move? | ☐ |
| **18**. | Does your job involve eating out a lot? | ☐ |
| **19**. | How many cans of food do you eat per week? | _____ |
| **20**. | How many slices of bread or rolls do you eat each week? | _____ |
| **21**. | How many pints of milk do you drink in a week? | _____ |
| **22**. | How many times a week do you eat live yoghurt? | _____ |
| **23**. | How many times a week do you eat red meat (beef, pork, lamb or game)? | _____ |
| **24**. | How many times a week do you eat white meat (poultry, fish)? | _____ |
| **25**. | What is your usual alcoholic drink? | _____ |
| **26**. | How many glasses do you drink a week? | _____ |
| **27**. | How would you describe your appetite? | |
| | **a)** poor | ☐ |
| | **b)** average | ☐ |
| | **c)** good | ☐ |

**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

Breakfast

Lunch

Dinner

Snacks/Drinks

## Day 2

Breakfast

Lunch

Dinner

Snacks/Drinks

**Are these two days representative of your usual eating habits? If not, what is a more usual day?**

Breakfast

Lunch

Dinner

Snacks/Drinks

**What Nutritional Supplements do you take daily on a regular basis?**