



Nutrition Programme Questionnaire

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: _____

Telephone Number: (Work) _____ (Home) _____

Occupation: _____ Age: _____

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 eg: 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? 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

What illness is/was your father prone to?

and sex. _____

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 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 of 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

LIFESTYLE ANALYSIS

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 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

- _____ 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 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

- _____ 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

- _____ 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

Underline the following that 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 underline.

Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.

Do you have any allergies? _____ If so what? _____

State type of reaction? _____

Have they 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 bloatedness, tiredness, irritability, depression, breast tenderness, headaches (*Please underline*)

DIET ANALYSIS

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

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

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.

<p>Day 1</p> <hr/> <p>Breakfast</p> <hr/> <p>Lunch</p> <hr/> <p>Dinner</p> <hr/> <p>Snacks/Drinks</p> <hr/>	<p>Day 2</p> <hr/> <p>Breakfast</p> <hr/> <p>Lunch</p> <hr/> <p>Dinner</p> <hr/> <p>Snacks/Drinks</p> <hr/>
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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?
