

# Nutritional Therapy Questionnaire

Please provide details as fully and accurately as possible. If at any time you need more space please continue on a separate sheet.

*Note: This form will be printed, please take care to not exceed the lines provided.  
For answers with multiple lines, please use the next line if you need more space.*

Title \_\_\_\_\_ First Name \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Post Code \_\_\_\_\_

Email \_\_\_\_\_ Phone numbers \_\_\_\_\_

Occupation \_\_\_\_\_ Work environment (e.g. city, farm) \_\_\_\_\_

# Health Profile

What is your main reason for seeking nutritional advice? \_\_\_\_\_

What outcome are you hoping to achieve? \_\_\_\_\_

Please list the health problems you would like to focus on. Continue on a separate sheet if you need more space.

Health Problem (e.g. arthritis)	Management so far (e.g. GP, operation, exercise, paracetamol etc.)	Onset	Duration
1.			
2.			
3.			
4.			
5.			

Have you had any recent health tests? Please specify or attach, if appropriate \_\_\_\_\_

Have you had any other major surgery, biopsies, diagnosed medical conditions, significant periods of ill health or do you suffer from any chronic or niggling health problems? (please give details e.g. high blood pressure, frequent colds, recurrent urinary infections etc.)

Do you suspect your symptoms relate to a particular event or time in your life? \_\_\_\_\_

## Medication & Supplements

Please list **anything you take regularly** including GP prescribed medication, self-prescribed medication (e.g. painkillers) nutritional supplements, herbal or homeopathic remedies. Continue on a separate sheet if necessary.

Prescription medication/ supplement	Dose	Condition being treated	Frequency & Duration

Antibiotic history: please state when and why you last took antibiotics plus any previous times you can remember:

# Body Scan

## Head

headaches, migraine, stiff neck, fuzzy headed, dizziness, poor balance pounding head, feeling of hangover, *unexplained pain*

## Hair

oily, dry, poor condition, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decreased body hair

## Mouth

sore tongue, tooth decay, mouth ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, *difficult swallowing*, hoarse voice, gingivitis, bleeding gums, cold sores

## Eyes

burning, gritty, protruding, prone to infection, sticky, itchy, *painful*, poor night vision, dry cataracts, sensitive to light, bags, swollen eyelids, *blurred vision*, double vision, failing eyesight, yellowish

## Ears

blocked, sore, itchy, weeping, watery, overly waxy, creased earlobe

## Nose

stuffy, congested, runny, *frequent nose bleeds*, prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

## Muscles

tender, sore, cramps, spasms, twitches, loss of tone, wasting, weak, stiff, frozen, 'restless legs', numbness

## Skin

dry, rough, flaky, scaly, puffy, pale, brown patches, *change in moles or lesions*, prematurely lined, congested, oily, clammy, yellow

## Skin prone to

acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

## Joints (fingers, knees, back, shoulders etc.)

painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

## Mood

(please underline your predominant states - even if they conflict)  
*depressed*, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, annoyed, overwhelmed, *suicidal*, fluctuating, aggressive

## Mind

forgetful, difficulty learning new things, easily confused, difficult concentrating, easily frustrated, easily distracted, difficult to make decisions, can't switch off, loss of interest in daily life, fogginess, dyslexia, dyspraxia, hyperactive, panic attacks, no motivation

## Chest

frequent colds and chest infections, asthma, bronchitis, diagnosed heart condition, palpitations, *chest discomfort/pain*, short of breath, difficulty breathing, wheezing, *persistent cough*, noisy breathing

## Gut

bloated, tender, cramping, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, *painful*, irritable bowel syndrome, coeliac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, constipation, diarrhoea

## Genitals

itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, *painful or frequent urination*, unexplained discharge

## Hands

dry, cracked, eczema, sore joints, puffy, cold, chilblains, *numbness*, tingling, feel clumsy & uncoordinated, poor circulation

## Nails

fragile, dry, brittle, flaky, peeling, splitting, hangnails (split cuticles), ridged, spoon shaped, white spots on more than 2 nails, horizontal white lines, thickened, or 'horny, dark nails', pale nail bed, infected

## Legs & Feet

restless legs, swollen, aching, athlete's foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, *numb*, pricking.

### Important Symptoms:

Please indicate by underlining if you suffer from any of the following symptoms which may require additional medical care:

persistent or unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine, stools; breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash or weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy

## Your vital statistics

\_\_\_\_\_ What is your normal blood pressure?  
\_\_\_\_\_ your resting pulse rate?  
\_\_\_\_\_ your current weight?  
\_\_\_\_\_ your height?  
\_\_\_\_\_ your waist circumference? (if known)  
\_\_\_\_\_ your hip circumference? (if known)  
\_\_\_\_\_ your blood type? (if known)  
\_\_\_\_\_ Is your weight stable, increasing or decreasing?  
\_\_\_\_\_ Did you have the normal immunisations as a child?

## Your family history

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc.) State disease, age at onset, gender.

Grandparents: \_\_\_\_\_  
\_\_\_\_\_

Parents: \_\_\_\_\_  
\_\_\_\_\_

Siblings: \_\_\_\_\_  
\_\_\_\_\_

Children: \_\_\_\_\_  
\_\_\_\_\_

## Your daily life

\_\_\_\_\_ Do you enjoy your daily life?  
\_\_\_\_\_ How many people depend on your support?  
\_\_\_\_\_ Do you feel supported by people around you?  
\_\_\_\_\_ Are you recently separated/divorced/a new parent?  
\_\_\_\_\_ Are you recently bereaved?  
\_\_\_\_\_ Have you moved house or changed jobs recently?  
\_\_\_\_\_ Do you work long or irregular hours?  
\_\_\_\_\_ Is your workload bigger than you can manage?  
\_\_\_\_\_ Are you under significant stress in any other way?  
\_\_\_\_\_ Do you feel guilty when you are relaxing?  
\_\_\_\_\_ Do you have a strong drive for achievement?  
\_\_\_\_\_ Do you often do 2 or 3 tasks simultaneously?  
\_\_\_\_\_ Do you take regular exercise?  
\_\_\_\_\_ Do you have any active hobbies?  
\_\_\_\_\_ Do you sleep well?  
\_\_\_\_\_ What do you do for relaxation?

## Your digestion

**Yes No** Do you regularly experience...  
  Indigestion (after food or between meals?)  
  Indigestion after fatty food?  
  Frequent burping / belching  
  Bowel movement shortly after eating?  
  Frequent stomach upsets or stomach pain?  
  Nausea or vomiting?  
  Pain between the shoulders or under the ribs?  
  Constipation or hard-to-pass stools?  
  Diarrhoea or 'urgency to go'?  
  Blood or mucus in stools?  
  Flatulence (wind)  
  Undigested food in stools?  
  Generally inconsistent bowel movements?  
  Anal itching?  
  Thrush or cystitis?  
\_\_\_\_\_ How many bowel movements do you have in 24 hours?  
\_\_\_\_\_ Have you noticed any recent change in bowel habit?  
\_\_\_\_\_ Are your stools pale, mid brown, dark brown, black, grey?  
\_\_\_\_\_ Have you ever had a stomach upset after foreign travel?  
\_\_\_\_\_ Do any foods cause digestive problems? (which ones?)  
\_\_\_\_\_

## Your toxic exposure

**Yes No**  
  Do you live, exercise or work in a city or by a busy road?  
  Do you live close to an agricultural area?  
  Do you drink unfiltered water?  
  Do you drink alcohol? If so, how many units a week? \_\_\_\_\_  
  What is your normal alcoholic drink? \_\_\_\_\_  
  Do you smoke/vape? If so, how many a day? \_\_\_\_\_  
  Do you live in a smoky atmosphere?  
  Do you think you may be addicted to anything?  
  Do you spend a lot of time in front of a tv / phone / screen?  
  Do you sunbathe / use sun beds?  
  Are you a frequent flyer?  
  Are you exposed to chemicals through work or hobby?  
  Do you heat, freeze or wrap food in plastics?  
  Do you regularly take antacid (indigestion) medication?  
\_\_\_\_\_ Roughly what percentage of your food is organic?  
  Do you frequently fry or roast food at high temperatures?  
  Do you regularly eat browned or barbecued foods?  
  Do you eat oily fish or shellfish more than 3 x a week?  
  Do you regularly consume artificial sweeteners?  
  Do you floss your teeth regularly?  
  Are your teeth filled with mercury amalgams?

## Your Energy Levels

- \_\_\_\_\_ Do you need more than 8 hours sleep per night?  
\_\_\_\_\_ Is your energy less than you want it to be?  
\_\_\_\_\_ Do you find it difficult to get going in the morning?  
\_\_\_\_\_ Do you feel drowsy during the day?  
\_\_\_\_\_ What time(s) of day is your energy lowest?  
\_\_\_\_\_ Do you get dizzy or irritable if you don't eat often?  
\_\_\_\_\_ Do you use caffeine, sugar or nicotine to keep going?  
\_\_\_\_\_ Do you find it difficult to concentrate?  
\_\_\_\_\_ Do you feel dizzy or light-headed if you stand up quickly?  
\_\_\_\_\_ Do you suffer from unexplained fatigue or listlessness?

## Women Only

- \_\_\_\_\_ Are you pregnant? If so, how many weeks? \_\_\_\_\_  
\_\_\_\_\_ Are you trying to become pregnant?  
\_\_\_\_\_ Are you breast-feeding at present?  
\_\_\_\_\_ How many children have you had?  
\_\_\_\_\_ Have you had problems with fertility?  
\_\_\_\_\_ Have you ever had a miscarriage?  
\_\_\_\_\_ What contraception do you use?  
\_\_\_\_\_ **Are you still menstruating?**  
\_\_\_\_\_ Are you or have you been on HRT?  
\_\_\_\_\_ Are your periods regular?  
\_\_\_\_\_ Any bleeding or spotting in between?  
\_\_\_\_\_ **Are your periods particularly heavy or painful?**  
\_\_\_\_\_ Do you suffer from PCOS, fibroids, endometriosis?  
\_\_\_\_\_ Any known genito-urinary conditions?  
\_\_\_\_\_ Are you happy with your sex drive?

**Menstruating Women:** please indicate by underlining if you experience: pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches.

**Menopausal Women:** please highlight if you suffer from: hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

## Men Only

- \_\_\_\_\_ Do you experience mood swings or depression?  
\_\_\_\_\_ Loss of sex drive?  
\_\_\_\_\_ Loss of motivation and drive?  
\_\_\_\_\_ Any known genito-urinary conditions?  
\_\_\_\_\_ Fertility problems?  
\_\_\_\_\_ Problems achieving or maintaining an erection?  
\_\_\_\_\_ Frequent or difficult urination?  
\_\_\_\_\_ Prostate problems  
\_\_\_\_\_ Wake at night to urinate  
\_\_\_\_\_ Difficult to start or stop urine stream  
\_\_\_\_\_ Pain or burning when urinating

## Eating Habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find hard to give up?

- \_\_\_\_\_ Do you cater for a special diet in the household?  
\_\_\_\_\_ Who does the cooking in your household?  
\_\_\_\_\_ Do you avoid any food for cultural/ethical reasons?  
\_\_\_\_\_ Do you suspect any foods don't agree with you?  
\_\_\_\_\_ Have you recently changed your diet?  
\_\_\_\_\_ Do you eat on the move/when stressed?  
\_\_\_\_\_ Do you ever have eating binges?  
\_\_\_\_\_ What do you binge on?  
\_\_\_\_\_ Have you ever suffered from an eating disorder?  
\_\_\_\_\_ Do you chew your food thoroughly?  
\_\_\_\_\_ Are you excessively thirsty?

*Please complete the separate food and lifestyle diary*

## Health Care Providers

Is this your first visit to a Nutritional Therapist?

How did you find out about me?

GP's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Are any other therapists/clinics involved in your care? Please list:

*I have disclosed all the relevant information applicable to this consultation and my health status at this point in time. I consent for the information provided to be used by my Nutritional Therapist and for my therapist to liaise with appropriate health professionals.*

Signed \_\_\_\_\_ Date \_\_\_\_\_