

# FOOD FOR LIFE

## nutrition programme questionnaire

Please complete as fully as possible.

**CONFIDENTIAL**

<b>Full name:</b>
<b>Address:</b>

Tel. (h):
Tel. (w):
Mob:
e-mail:

<b>Personal details.</b>		
Height:	Resting pulse:	Doctor's name & address:
Weight:	Blood pressure: (if known).	
Date of birth:		
Occupation:	Children or other dependants (Please give gender and age)	Are they aware that you are visiting a Nutritional Therapist? Y/N?  Permission to contact: Y/N?

<b>Goals &amp; objectives:</b>
1. Reasons for / objectives in seeking nutritional advice: a)  b)  c)  d)

Current life goals (e.g. career, family, health):
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What (if any) illnesses are present on your mother's / father's side of the family?
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**Medical History.** Please list any illnesses or operations (excluding colds or flu, unless persistent) starting from your childhood, to the present day.

Condition / illness / Operation	Age of Onset	Duration	Medication prescribed / taken?

Please give name and details of any current diagnosed condition or disease?

Was this diagnosed by a Doctor  or Complimentary Health Practitioner ? (Please tick)

If you are currently undergoing any form of medical treatment please give details? (Include name, dose and regularity of consumption.)

### Symptoms profile

Please place an "x" in the appropriate box if, over the last year, you have experienced any of the following symptoms: 1. Occasionally 2. Frequently

1	2	Digestion
		Constipation
		Diarrhoea
		Bloating
		Flatulence
		Anal irritation / itching
		Heartburn

1	2	Musculo-skeletal
		Joint aches / pains
		Muscle tremor / twitching
		Cramps
		Inability to build muscle
		Aching muscles after training

1	2	Hormonal system
		Cravings for sweet foods
		Lack of energy
		PMS (Women only)

1	2	Immunity
		Colds or flu
		Infections
		Thrush / cystitis (women only)

1	2	Mind / memory
		Poor memory
		Inability to concentrate
		Insomnia
		Irritability /short temper
		Depression
		Anxiety

1	2	Skin & nails
		Athletes Foot
		Dry / flaky skin
		Pale skin
		Acne
		Brittle / flaking nails
		White marks on finger nails
		Fungal nails (yellow)

1	2	Cardio-vascular & respiratory
		Shortness of breath
		Wheezing / congestion
		Mucous production
		Irregular heart beat
		Noticeable heart beat

**Nutritional supplementation and complimentary therapies**

Do you take any nutritional supplements, herbal or homeopathic remedies (regularly or occasionally)? If so, please list including doses and manufacturers name.

Have you ever visited a complimentary therapy practitioner (e.g. osteopath, acupuncturist, herbalist etc.). Please give information re: dates and treatment.

**Food and dietary choices**

Do you follow or have you ever followed any dietary plan, regime or principles e.g. Atkins / high protein, vegetarian, food combining, GI principles, raw foods? If yes please list.

How often do you shop for fresh food?

Do you choose organic foods?

Do you enjoy preparing food?

Do you use a microwave?

What food or meal would you eat as a treat?

Are there any foods you would find hard to give up?

Are there any foods or drinks that you avoid or adversely effect you?

How willing are you to change the way you eat and experiment with new foods?

Reluctant  Willing to experiment  Enthusiastic about change

(Please tick or "x" one. Feel free to be honest. There is no "right" answer.)

**Lifestyle choices**

How much time per day do you spend on your mobile phone or Blackberry?

Do you have a wireless internet connection?

Do you drink tap water (including tea / coffee)?

What do you do in order to relax?

How many units of alcohol do you consume per week? (1 pint beer = 2, 1 glass wine = 1.5)

Do you smoke?

**What do you consider to be your greatest strength?**