NUTRI-FIT

Believe you can change

Nutritional Therapy Questionnaire

Please complete this questionnaire as fully and as accurately as possible.

Title: _____ Name: _____ D.O.B.: _____ Age: _____

Address: _____

_____

Tel: _____ Mob: _____ Email: _____

Occupation: _____

What is your reason(s) for needing nutritional advice?: _____

_____

What are your health goals?: _____

Please list current health problems that you need treating in the table below.

	Health problem eg, Colitis	Treatment so far eg, GP, Operation, Exercise referral	Since when and frequency
Problem 1			
Problem 2			
Problem 3			

Have you had any recent health tests?: _____

Have you had any major surgery, diagnosed medical conditions, long periods of ill health or suffer with any constant niggling health problems? (please give details)ie, High blood pressure, recurrent urinary infections:

_____

_____

_____

When did these symptoms start? (Is there a trigger?): _____

Medications/Remedies – (please list anything you take on a regular basis including GP prescriptions, self-prescribed medication, nutritional supplements, herbal or homoeopathic remedies)

Remedy	Dose	Condition being treated	Dose and Quantity
1.			
2.			
3.			

Please state when and why you last took antibiotics, and any previous times that you can remember?:

_____

_____

Body Check

Please tick as appropriate those which best describe how you are affected in the areas of the body.

Head: headaches ☐ migraine ☐ stiff neck ☐ dizziness ☐ poor balance ☐ unexplained pain ☐
Other: _____

Hair: oily ☐ dry ☐ thinning ☐ brittle ☐ increased body hair ☐ decreased body hair ☐
dandruff ☐ Other: _____

Mouth: sore tongue ☐ tooth decay ☐ ulcers ☐ bad breath ☐ dry mouth ☐ gingivitis ☐
bleeding gums ☐ cold sores ☐ Other: _____

Eyes: burning ☐ itchy ☐ poor night vision ☐ swollen eyelids ☐ yellowed ☐ painful ☐ bags ☐
blurred vision ☐ sensitive to light ☐ cataracts ☐ Other: _____

Ears: blocked ☐ itchy ☐ waxy ☐ sore ☐ weeping ☐ Other: _____

Nose: stuffy ☐ congested ☐ runny ☐ sinusitis ☐ hay fever ☐ sneezing ☐ poor sense of smell ☐
rhinitis ☐ prone to snoring ☐ Other: _____

Muscles: tender ☐ sore ☐ spasms ☐ wasted ☐ weak ☐ frozen ☐ restless legs ☐ numbness ☐
twitches ☐ Other: _____

Skin: dry ☐ flaky ☐ oily ☐ blemish prone ☐ regular breakouts ☐ itchy ☐
Other: _____

Joints: painful ☐ swollen ☐ arthritic ☐ aching ☐ reduced mobility ☐ slow movement ☐
inflamed ☐ unsteadiness ☐ rheumatic ☐ Other: _____

Hands & nails: flaky nails ☐ spotted nails ☐ ridged nails ☐ sore ☐ puffy ☐ reduced & clumsy movement ☐
Other: _____

Moods: happy ☐ optimistic ☐ anxious ☐ sad ☐ aggressive ☐ fluctuating ☐ cheerful ☐ tense ☐
balanced ☐ worried ☐ can't be bothered ☐ overwhelmed ☐ aggitated ☐
Other: _____

Mind: forgetful ☐ easily confused ☐ panic attacks ☐ can't switch off ☐ no motivation ☐
difficulty in learning new things ☐ difficulty in concentrating ☐ dyslexia ☐ hyperactive ☐
easily frustrated ☐ Other: _____

Chest: wheezing ☐ asthma ☐ diagnosed heart condition ☐ chest discomfort/pain ☐ palpitations ☐
frequent colds and chest infections ☐ noisy breathing ☐ persistent cough ☐
Other: _____

Gut: distended ☐ bloated ☐ acid reflux ☐ painful ☐ sensitive ☐ constipation ☐ sluggish ☐
diarrhoea ☐ flatulence ☐ heartburn ☐ cramping ☐ nausea ☐ sensation of fullness ☐
celiac ☐ polyps ☐ ulcers ☐ hiatus hernia ☐ Other: _____

Legs & feet: Restless legs ☐ swollen ☐ aching ☐ fungal nails ☐ burning feet ☐ gout ☐ sciatica ☐
cold feet ☐ numb ☐ athlete's foot ☐ Other: _____

Other important issues: Increased urination ☐ excessive thirst ☐ swelling ☐ loss of appetite ☐ excessive bruising ☐
inability to gain or lose weight ☐ slurred speech ☐ vomit ☐ stools ☐
Other: _____

Vital Statistics

Blood type: _____ Blood pressure: _____ Resting pulse: _____ Current weight: _____

Waist/hip circumference: _____ Child vaccines? No ☐ Yes ☐

Your Digestion

Please check the box adjacent to the health conditions that affect you.

Indigestion after food or between meals ☐ Frequent stomach upsets or stomach pain ☐ Diarrhoea ☐

Bowel movement shortly after eating ☐ Blood/mucus in stools ☐ Nausea/vomiting ☐ Anal itching ☐

Thrush or cystitis ☐ undigested food in stools ☐

How many bowel movements do you have in 24 hours? _____

Have you noticed any recent change in bowel habit? _____

What colour are your stools? pale ☐ mid-brown ☐ brown ☐ black ☐ grey ☐ yellowish ☐

Have you ever had any stomach upsets/complaints when abroad? _____

Do any foods cause you digestive problems? _____

Family History

Do you have a family history of disease/allergies (eg, asthma, heart disease, diabetes). Please state disease, age of onset and gender.

Relative	Health condition	Age of Onset
Grandparents		
Parents		
Siblings		
Children		

Your Present Daily Life

Is your job active?	No ☐ Yes ☐	Do you sleep well?	No ☐ Yes ☐
Do you have active hobbies?	No ☐ Yes ☐	Do you often multi-task?	No ☐ Yes ☐
Do you feel guilty when relaxing?	No ☐ Yes ☐	Do you feel supported by people around you?	No ☐ Yes ☐
Do you work long/irregular hours?	No ☐ Yes ☐	Have you moved/changed job recently?	No ☐ Yes ☐
Do you have a strong drive for achievement?	No ☐ Yes ☐	Do you enjoy your daily life?	No ☐ Yes ☐

Energy Levels

How much sleep do you get per night? _____ hrs

you have a regular sleep pattern?? No ☐ Yes ☐

Do you feel drowsy during the day? No ☐ Yes ☐

At what time is your energy level lowest? _____

Do you get mood swings if you do not eat regularly? No ☐ Yes ☐

Do you ever find it difficult to concentrate? No ☐ Yes ☐

Do you use or have you used stimulants to keep you going? (coffee, sugar, nicotine) No ☐ Yes ☐

Women Only (please tick all that apply)

Are you pregnant? No ☐ Yes ☐

Are you trying to get pregnant? No ☐ Yes ☐

Are you breastfeeding at present? No ☐ Yes ☐

How many children do you have? No ☐ Yes ☐

Have you had any fertility problems? No ☐ Yes ☐

Have you ever had a miscarriage? No ☐ Yes ☐

Do you use any contraception? No ☐ Yes ☐

Are you still menstruating? No ☐ Yes ☐

Are your periods regular? No ☐ Yes ☐

Any bleeding/spotting in between? No ☐ Yes ☐

Are your periods heavy or painful? No ☐ Yes ☐

Do you suffer with PCOS, fibroids, endometriosis? No ☐ Yes ☐

Any known genito-urinary conditions? No ☐ Yes ☐

Are you happy with your sex drive? No ☐ Yes ☐

Menstruating women - do you experience any of the following symptoms

Pre-menstrual bloating ☐ tiredness ☐ irritability ☐ depression ☐ water retention ☐ headaches ☐ breast tenderness ☐
Other: _____

Menopausal women - do you experience any of the following symptoms

Flushes ☐ mood swings ☐ insomnia ☐ depression ☐ vaginal dryness ☐ Other: _____

Men Only (please tick all that apply)

Any prostate problems? No ☐ Yes ☐

Loss of sex drive? No ☐ Yes ☐

Loss of motivation/ drive? No ☐ Yes ☐

Fertility problems? No ☐ Yes ☐

Frequent or difficult to urinate? No ☐ Yes ☐

Wake at night to urinate? No ☐ Yes ☐

Any pain/burning during urination? No ☐ Yes ☐

Do you experience mood swings/depression? No ☐ Yes ☐

Any known genito –urinary infections? No ☐ Yes ☐

Health Care Professionals

Is this the 1st time you have visited a Nutritionist? No ☐ Yes ☐

How did you hear about me? _____

GP/Other name: _____

Address: _____

Tel: _____

Any other therapy you currently have? _____

I have disclosed all relevant information applicable to this consultation and my health status at this point in time. I consent for this information provided to be used by my Nutritionist and for this professional to liaise with appropriate health professional s if deemed necessary.

Client signature: _____

Date: _____