

# NUTRITION PROGRAMME QUESTIONNAIRE

PRIVATE AND CONFIDENTIAL

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:**

**E-mail:**

**Telephone number:** (Work)

(Home)

**Occupation:**

**Date of birth:**

**Your weight** (without clothes):

**Your height** (without shoes):

## 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: Headaces 5 years (Continue on a separate sheet if you need more space)

**Health Problem**

**Duration**

1

2

3

4

5

6

**What medication** (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 your siblings suffer from?

How many brothers and sisters do you have? State age and sex.

What illness is/was your father prone to?

What illness is/was your mother prone to?

## SYMPTOM ANALYSIS

This section lists symptoms associated with particular nutritional deficiencies. Tick the conditions you suffer from. You can select conditions by pointing and clicking with your mouse at the grey tick boxes. Some symptoms are repeated. Please tick them in all cases.

<b>Mouth ulcers</b>	<input type="checkbox"/>	Muscle tremors or cramps	<input type="checkbox"/>	<b>Muscle tremors or spasms</b>	<input type="checkbox"/>
Poor night vision	<input type="checkbox"/>	Apathy	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>
Acne	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Insomnia or nervousness	<input type="checkbox"/>
<b>Frequent colds or infections</b>	<input type="checkbox"/>	<b>Burning feet or tender heels</b>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Dry flaky skin	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Thrush or cystitis	<input type="checkbox"/>	Exhaustion after light exercise	<input type="checkbox"/>	Fits or convulsions	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
		Teeth grinding	<input type="checkbox"/>	Depression	<input type="checkbox"/>
<b>Rheumatism or arthritis</b>	<input type="checkbox"/>	Infrequent dream recall	<input type="checkbox"/>	<b>Pale skin</b>	<input type="checkbox"/>
Back ache	<input type="checkbox"/>	<b>Water retention</b>	<input type="checkbox"/>	<b>Sore tongue</b>	<input type="checkbox"/>
Tooth decay	<input type="checkbox"/>	Tingling hands	<input type="checkbox"/>	<b>Fatigue or listlessness</b>	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	Depression or nervousness	<input type="checkbox"/>	<b>Loss of appetite or nausea</b>	<input type="checkbox"/>
Excessive sweating	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<b>Heavy periods or blood loss</b>	<input type="checkbox"/>
Muscle cramps, or spasms	<input type="checkbox"/>	Muscle tremors or cramps	<input type="checkbox"/>		
<b>Joint pain or stiffness</b>	<input type="checkbox"/>	<b>Lack of energy</b>	<input type="checkbox"/>	Poor sense of taste or smell	<input type="checkbox"/>
Lack of energy	<input type="checkbox"/>	Flaky skin	<input type="checkbox"/>	<b>White marks on more than two finger nails</b>	<input type="checkbox"/>
Lack of sex drive	<input type="checkbox"/>	Poor hair condition	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>
<b>Exhaustion after light exercise</b>	<input type="checkbox"/>	Eczema or dermatitis	<input type="checkbox"/>	Stretch marks	<input type="checkbox"/>
<b>Easy bruising</b>	<input type="checkbox"/>	Mouth over sensitive to hot or cold	<input type="checkbox"/>	Acne or greasy skin	<input type="checkbox"/>
<b>Slow wound healing</b>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Low fertility	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>
Loss of muscle tone	<input type="checkbox"/>	<b>Lack of energy</b>	<input type="checkbox"/>	Tendency to depression	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>
		Tender or sore muscles	<input type="checkbox"/>	<b>Muscle twitches</b>	<input type="checkbox"/>
<b>Frequent colds</b>	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>	<b>Childhood 'growing pains'</b>	<input type="checkbox"/>
Lack of energy	<input type="checkbox"/>			<b>Dizziness or poor sense of balance</b>	<input type="checkbox"/>
<b>Frequent infections</b>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<b>Fits or convulsions</b>	<input type="checkbox"/>
Bleeding or tender gums	<input type="checkbox"/>	Cracked lips	<input type="checkbox"/>	<b>Sore knees</b>	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	Prematurely greying hair	<input type="checkbox"/>		
Nose bleeds	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>	<b>Family history of cancer</b>	<input type="checkbox"/>
Slow wound healing	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<b>Signs or premature ageing</b>	<input type="checkbox"/>
Red pimples on skin	<input type="checkbox"/>	<b>Lack of energy</b>	<input type="checkbox"/>	<b>Cataracts</b>	<input type="checkbox"/>
		Poor appetite	<input type="checkbox"/>	<b>High blood pressure</b>	<input type="checkbox"/>
Tender muscles	<input type="checkbox"/>	Stomach pains	<input type="checkbox"/>	<b>Frequent infections</b>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	Depression	<input type="checkbox"/>		
Irritability	<input type="checkbox"/>			<b>Excessive or cold sweats</b>	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	<b>Dry skin</b>	<input type="checkbox"/>	<b>Dizziness or irritability after 6 hours without food</b>	<input type="checkbox"/>
'Prickly' legs	<input type="checkbox"/>	Poor hair condition	<input type="checkbox"/>	Need for frequent meals	<input type="checkbox"/>
Poor memory	<input type="checkbox"/>	Prematurely greying hair	<input type="checkbox"/>	Cold hands	<input type="checkbox"/>
Stomach pains	<input type="checkbox"/>	<b>Tender or sore muscles</b>	<input type="checkbox"/>	Need for excessive sleep or drowsiness during the day	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<b>Poor appetite or nausea</b>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>
Tingling hands	<input type="checkbox"/>	<b>Eczema or dermatitis</b>	<input type="checkbox"/>	<b>'Addicted' to sweet foods</b>	<input type="checkbox"/>
Rapid heart beat	<input type="checkbox"/>				
		<b>Dry, rough skin</b>	<input type="checkbox"/>		
<b>Burning or gritty eyes</b>	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>		
<b>Sensitivity to bright lights</b>	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>		
Sore tongue	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>		
Cataracts	<input type="checkbox"/>	Loss of hair or dandruff	<input type="checkbox"/>		
Dull or oily hair	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>		
Eczema or dermatitis	<input type="checkbox"/>	Poor wound healing	<input type="checkbox"/>		
Split nails	<input type="checkbox"/>	PMS or breast pain	<input type="checkbox"/>		
Cracked lips	<input type="checkbox"/>	Infertility	<input type="checkbox"/>		
Lack of energy	<input type="checkbox"/>	<b>Muscle cramps or tremors</b>	<input type="checkbox"/>		
Diarrhoea	<input type="checkbox"/>	<b>Insomnia or nervousness</b>	<input type="checkbox"/>		
Insomnia	<input type="checkbox"/>	<b>Joint pain or arthritis</b>	<input type="checkbox"/>		
Headaches or migraines	<input type="checkbox"/>	<b>Tooth decay</b>	<input type="checkbox"/>		
Poor memory	<input type="checkbox"/>	<b>High blood pressure</b>	<input type="checkbox"/>		
Anxiety or tension	<input type="checkbox"/>				
Depression	<input type="checkbox"/>				
Irritability	<input type="checkbox"/>				
Bleeding or tender gums	<input type="checkbox"/>				
Acne	<input type="checkbox"/>				

# LIFESTYLE ANALYSIS

Please answer 'Yes' or 'No' to the questions below.

## 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 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 tea, coffee or a 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?

## 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 hay fever?
- \_\_\_\_\_ Do you suffer from allergy problems?
- \_\_\_\_\_ Have you had a major personal loss in the last year?

## Histamine Profile

Tick the following the apply to you:

- |  |  |
|--|--|
| <input type="checkbox"/> Sleep over 8 hours      | <input type="checkbox"/> Little sex drive            |
| <input type="checkbox"/> Much body hair          | <input type="checkbox"/> Infrequent colds            |
| <input type="checkbox"/> Sluggish metabolism     | <input type="checkbox"/> Slow to wake up             |
| <input type="checkbox"/> Short toes and fingers  | <input type="checkbox"/> Suspicious by nature        |
| <input type="checkbox"/> Fat of 'well covered'   | <input type="checkbox"/> Can tolerate pain           |
| <input type="checkbox"/> Sleep less than 7 hours | <input type="checkbox"/> Strong sex drive            |
| <input type="checkbox"/> Little body hair        | <input type="checkbox"/> Family history of allergies |
| <input type="checkbox"/> Fast metabolism         | <input type="checkbox"/> 'Morning person'            |
| <input type="checkbox"/> Long toes and fingers   | <input type="checkbox"/> Tends towards depression    |
| <input type="checkbox"/> Don't put on weight     | <input type="checkbox"/> Poor tolerance of pain      |

## Allergy Profile

Do you suffer from any of the following? Please tick

- |   |   |
|---|---|
| <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Migraine                 |
| <input type="checkbox"/> Hay fever      | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Eczema         | <input type="checkbox"/> Frequent bloatedness     |
| <input type="checkbox"/> Dermatitis     | <input type="checkbox"/> Facial puffiness         |
| <input type="checkbox"/> Asthma         |   |

Do you have any allergies? \_\_\_\_\_

If so, what? \_\_\_\_\_

State type of reaction? \_\_\_\_\_

Have you 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 symptoms? (tick which ones)

<input type="checkbox"/> Bloating	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Headaches

# DIET ANALYSIS

Please answer 'Yes' or 'No' or indicate 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 deep-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 confectionary?</p> <p>13. _____ What percentage of your diet is <b>raw</b> fruit and <b>raw</b> 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? (<i>beef, pork, lamb or game</i>)</p> <p>20. _____ How many times a week do you eat white meat? (<i>poultry, fish</i>)</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?<br/> <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> 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.**

**Day 1**

Breakfast

Lunch

Dinner

Snacks/Drinks

**Day 3**

Breakfast

Lunch

Dinner

Snacks/Drinks

**Day 2**

Breakfast

Lunch

Dinner

Snacks/Drinks

**What nutritional supplements do you take daily on a regular basis?**

I hereby confirm that this information is correct to the best of my knowledge and that I am not withholding any important information.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_