**NUTRITIONAL ASSESSMENT QUESTIONNAIRE**

**Private and Confidential**

**Information will not be disclosed to third parties unless consent is given by the client.**

**Please complete this document giving as much information as possible.**

**Client Details**

Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth Age

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

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Telephone

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex Marital Status Children

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height Weight

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GP Details**

Name

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Address

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Telephone

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**Your Hereditary Profile**

What major diseases or illnesses is / was your father prone to?

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What major diseases or illnesses is / was your mother prone to?

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What major diseases or illnesses are / where your siblings prone to?

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What major diseases or illnesses are / where your children prone to?

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Where you born by natural birth or caesarian section?

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Where you breastfed, if yes for how long?

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What illnesses did you have as a child?

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What illnesses have you had in the past 10 years?

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What surgical operations have you had?

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**Your Lifestyle Profile**

How much exercise do you have a week?

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Do you work 60 hours a week or more?

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Do you smoke, if so how many cigarettes a day?

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Do you live or work in a smoky environment?

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Do you drink more than 1 unit of alcohol a day?

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Do you spend more than 2 hours a day in traffic?

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Do you spend much time by a TV or on a computer?

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Do you take medication, contraception pill, self prescribed medication, recreational drugs, if so what’s your reason for taking them, duration, dose?

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Do you take herbal/natural supplements, if so what’s your reason for taking them, was it prescribed or self prescribed, dose, brand?

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When relaxing do you feel guilty?

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Do you become angry easily and by trivial things?

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Is your energy less than it used to be?

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Are you unclear about where you are going, what you want to do and your goal in life?

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Do you have difficulty falling asleep, wake up often, have trouble getting back to sleep?

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Do you remember your dreams?

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How many meals a day do you eat with your family?

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Do you eat on the go, standing up or driving?

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Is your hair dry, oily, prone to falling out?

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**Systems Review**

Please tick the right hand box of all the symptoms you are experiencing:

|  |  |
| --- | --- |
| **Upper Gastrointestinal Tract – mouth to duodenum** |  |
| Belching/Burping or gas within 1 hour of eating a meal |  |
| Suffer from Heartburn or Acid Reflux |  |
| Bloating shortly after eating |  |
| Suffer from Bad Breath (Halitosis) |  |
| Feelings of excessive fullness after meals |  |
| Find you eat quickly, finishing before everyone else |  |
| Often feel like skipping breakfast |  |
| Feel better by not eating |  |
| Feel sleepy after meals |  |
| Have fingernails that break, peel or chip easily |  |
| Suffer from stomach pains and or cramps |  |
| Take indigestion tablets |  |
| Notice undigested food in your stool |  |
| Have diarrhoea after meals |  |

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| **Liver & Gallbladder** |  |
| Suffer from stomach upset after eating greasy food |  |
| Nausea |  |
| Stools that are light or clay coloured |  |
| Have had your gallbladder removed |  |
| Easily intoxicated by alcohol |  |
| Have a history of drug/alcohol abuse |  |
| Have a history of hepatitis |  |
| Long term use of prescription medications |  |
| Sensitive to chemicals (perfumes, cleaning products, insecticides, car fumes) |  |

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| **Small Intestine – between the stomach & the large intestine** |  |
| Suffer from food intolerances/allergies |  |
| Suffer from bloating 1-2 hours after food |  |
| Find specific foods make you tired or bloated |  |
| Notice an increased heart rate/pulse rate after food |  |
| Suffer with hay fever |  |
| Crave certain foods |  |
| Suffer with sinus infections/stuffy nose/asthma |  |
| Sometimes feel spaced out |  |
| Have alternating constipation then diarrhoea |  |
| Suffer from Urticaria (hives) |  |

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| **Large Intestine – ileum to anus** |  |
| Itchy anus |  |
| Coating on the tongue |  |
| Suffer with fungal infections to nails, athletes foot or yeast infections; candida or thrush |  |
| Hard stools which are difficult to pass |  |
| Parasite infections |  |
| Cramping in the lower abdomen |  |
| Less than 1 bowel movement a day |  |
| Loose stools or not well formed |  |
| Irritable bowel |  |
| Mucous in the stool |  |
| Blood in the stool |  |
| Foul smelling lower body gas |  |
| Strong body odour |  |
| Bad breath (Halitosis) |  |
| Suffer with haemorrhoids |  |

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| **Cardiovascular System - circulation** |  |
| Chest Pain |  |
| Wheezing / Shortness of breath / Asthma |  |
| Tonsilitis |  |
| Heart Palpitations |  |
| Water retention |  |
| Fainting |  |
| Varicose veins |  |
| Cold hands and feet |  |
| Blood pressure issues |  |
| High cholesterol |  |
| Tinnitus |  |
| Overweight |  |

Please tick the right hand box of all the symptoms you are experiencing:

|  |  |
| --- | --- |
| **Immune System & Allergies** |  |
| Never get ill |  |
| Have a constant runny nose |  |
| React to dog and or cat fur |  |
| Take a long time to heal |  |
| Suffer with frequent infections to ears, lungs, skin, bladder, kidneys |  |
| Atopic disease eg asthma / eczema / Itchy skin / dermatitis |  |
| Autoimmune disease eg rheumatoid arthritis, Multiple sclerosis, lupus, psoriasis |  |
| Have cysts, boils or rashes |  |
| Get frequent colds or flu |  |
| Suffer with shingles, herpes, hepatitis, chronic fatigue, cold sores |  |
| Bruise easily |  |

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| **Nervous System** |  |
| Headache/Migraine |  |
| Visual disturbance |  |
| Dizziness |  |
| Vertigo |  |
| Fainting |  |
| Fits |  |
| Nervous tics |  |
| Mood changes |  |
| Emotional imbalances |  |
| Anxiety |  |
| Memory and Concentration |  |
| Depression |  |
| Sleep disturbances |  |
| Night sweats |  |

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Please tick the right hand box of all the symptoms you are experiencing:

|  |  |
| --- | --- |
| **Musculo-skeletal System** |  |
| Joint pain |  |
| Stiffness |  |
| Joint swelling |  |
| Back pain |  |
| Neck pain |  |
| Injuries |  |
| Spasms |  |
| Cramps |  |

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| **Men** |  |
| Constant need to urinate |  |
| Difficulty starting & stopping urine flow |  |
| Pain or burning sensation when urinating |  |
| Prostate issues |  |
| Decreased libido |  |
| Constipation |  |
| Erectile dysfunction |  |
| STD’s (sexually transmitted disease) |  |
| Strong smell & dark colour of urine |  |
| UTI’s urinary tract infection |  |

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| **Women** |  |
| Erratic periods |  |
| Heavy blood flow during periods |  |
| Light to non existent blood flow during periods |  |
| Skipped periods |  |
| PMS |  |
| Food cravings around period |  |
| Breast tenderness |  |
| Water retention |  |
| STD’s |  |
| Thrush |  |
| Decreased libido |  |
| Complications during pregnancy |  |
| Vaginal dryness/itchiness |  |
| Excess facial/body hair |  |
| Hot flushes |  |
| Strong smell & dark colour of urine |  |
| UTI’s |  |

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| **Endocrine System – Adrenals, Thyroid & Sugar Control** |  |
| Blood sugar fluctuations |  |
| Highs & lows of energy levels |  |
| Low blood sugar attacks – hypoglyceamia |  |
| Sugar cravings |  |
| Salt cravings |  |
| Frequent urination |  |
| Excessive thirst |  |
| Weight gain or loss |  |
| Swelling in the throat – presence of goitre |  |
| Insomnia |  |
| Slow to start in the morning |  |
| Coffee makes you wired, gives you the jitters |  |
| Clench / grind teeth |  |
| Become dizzy when suddenly stand up |  |
| Feel fatigued in your muscles |  |
| Feel drowsy often |  |
| Chronic fatigue |  |
| Yawning in the afternoon |  |
| Headaches in the afternoon |  |
| Allergies and or hives |  |

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| **Thyroid** |  |
| Difficulty gaining weight |  |
| Difficulty losing weight |  |
| Struggle working under pressure |  |
| Nervous, emotional |  |
| Flush easily |  |
| Fast pulse when resting |  |
| Intolerance to heat |  |
| Mentally sluggish |  |
| Can’t be bothered attitude |  |
| Sleepy during the day |  |
| Poor circulation – cold sensitive |  |
| Constipation |  |
| Loss of lateral third of eyebrow |  |
| Seasonal sadness |  |

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| **Sugar** |  |
| Crave sweets |  |
| Eat desserts and sugary snacks |  |
| Once start eating sugar can’t stop – uncontrolled |  |
| Have to eat sugar in the afternoon |  |
| Sleepy in the afternoon – body slump |  |
| Irritable and or suffer with headaches if meals are delayed or skipped |  |
| Shaky if meals are delayed |  |
| Diabetes in family |  |
| Frequent thirst |  |
| Frequent urination |  |

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| **Fats - Essential Fatty Acids** |  |
| Poor memory and loss of concentration |  |
| Suffer with dry eyes |  |
| Suffer with PMS/PMT |  |
| Excessive thirst or sweating |  |
| Dry flaky skin or dandruff |  |

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| **Micronutrients - Vitamin & Mineral Requirements** |  |
| Sore tongue |  |
| Small bumps on back of arms |  |
| White spots on finger nails |  |
| Wounds slow to heal |  |
| Bleeding gums especially whilst brushing |  |
| Decreased sense of taste or smell |  |
| Vulnerable to insect bites |  |

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**Any additional information…**

**Please send your completed form to**

**288 Queens Park Road BN2 9ZL or** **fishbev@hotmail.co.uk**

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