# HEALTH QUESTIONAIRE

# PRIVATE AND CONFIDENTIAL

It is important that you answer all the questions so that I can evaluate your health as accurately as possible. (***If you are editing the document, highlight where you have been asked to tick/circle and email me the completed version***)

## GENERAL DETAILS

Name…….Date…….

Address……..

……

Postcode:……

Tel: (home)…… Work…… Mobile……

E-mail……

DOB……..Age……....Weight……Height……

Occupation…….

Married Divorced Single

Children/dependents (sex and age)
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Hobbies……...

Reasons for seeking a Nutritional consultation……...
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How did you hear about me? .....

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As a **Nutritional Therapist** I do not diagnose or treat disease. Our objective is for us to work together on your health, diet and lifestyle and bring the body into balance and a state of optimum health, thereby encouraging the body's own healing and resistance to disease.

I would like your permission to contact your general practitioner should I feel it helpful.

Please sign consent: _____
Date: _____

Name of GP: _____
Address:
_____
_____

Telephone No._____

## GENERAL HEALTH PROFILE

Have you seen other therapists before, if so what advise where you given?
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***Please list all health problems concerning you at the moment***

**Current problems** **Symptoms** **Duration** **Medication**

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Are you being treated medically by the doctor, if so please explain?

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Yes No

Do you smoke? ____
If so how many per day? ____

Do you drink Alcohol? ____
If so how many units per week? ____

Are you taking any Supplements?
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Are you taking any Medication?
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Would you say your health is:

- ☐ Poor.
- ☐ Fair
- ☐ Good
- ☐ Very good
- ☐ Excellent

How does this compare with a year ago?

- ☐ Much worse
- ☐ Slightly worse
- ☐ The same
- ☐ Slightly better
- ☐ Much better

Are you experiencing anything particularly stressful at the moment?
…….

Have you experienced any significant stressful event i.e. divorce, bereavement, redundancy, etc.
…….

**WORK**

How many hours do you work per day? ……

Is your job stressful? .....

Do you take a lunch break and for how long? ……

Do you skip meals, if so which one? ……

Do you have facilities at work for lunch, or do you eat out……

Do you exercise regularly?

☐ Yes
☐ No

If yes, explain your routine……..

Would you like to do more exercise, if so what? .....

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**PREVIOUS MEDICAL HISTORY**

***Please list*** any previous illnesses, diseases, allergies, accidents or operations
(***Please continue overleaf if necessary***)

**Date** **Symptoms**

**Hospitalised/medication**

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**FAMILY MEDICAL HISTORY**

Please list any illnesses or medical conditions your family have had, has or died from including Father, Mother, Grandparents, Siblings and Children.

**Date** **Age** **Illness/Condition**

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**Sign or Symptoms Checklist**

***Please tick*** *anything below you have suffered* ***significantly*** *from in the past 3 months:*
When alternative symptoms (e.g. nausea or vomiting) are given please circle the relevant condition(s)

- ☐ Not chewing thoroughly
- ☐ Reflux
- ☐ Diarrhoea
- ☐ Nausea or vomiting
- ☐ Stomach pains or prone to stomach upsets
- ☐ Passing wind/flatulence
- ☐ Haemorrhoids/piles
- ☐ Bolting or rushing meals
- ☐ Indigestion or heartburn
- ☐ Constipation
- ☐ Bloating
- ☐ Coated tongue or bad breath
- ☐ Anal irritation
- ☐ Mucus or blood in the stools

- ☐ Irregular or rapid heart beat
- ☐ Chest pains
- ☐ High blood fats - cholesterol, triglycerides
- ☐ Weight control problems
- ☐ Dizziness
- ☐ Migraines or headaches
- ☐ High or low blood pressure
- ☐ Smoker
- ☐ Anaemia
- ☐ varicose veins

- ☐ Frequent colds or infections
- ☐ Prone to thrush or cystitis
- ☐ Eczema or dermatitis
- ☐ Hay fever
- ☐ Any allergies, ***please specify***
- ☐ Arthritis or inflammation
- ☐ Mouth ulcers
- ☐ slow wound healing
- ☐ Colds/infections hard to shift
- ☐ Do you often take antibiotics
- ☐ Asthma or bronchitis
- ☐ Nasal problems, ***please specify***
- ☐ Water retention
- ☐ Joint pain or stiffness
- ☐ Prone to cold sores or herpes
- ☐ Chemical sensitivities

- ☐ Lack of energy or fatigue
- ☐ Irritable, dizzy, weak or shaky if meals missed
- ☐ Very thirsty or frequent urination
- ☐ Slow to wake up
- ☐ Need for excessive sleep
- ☐ Mood swings
- ☐ Need for frequent meals
- ☐ Sweat a lot
- ☐ Weight control problems
- ☐ Drowsiness during the day
- ☐ Craving for sweet foods or stimulants
- ☐ Headaches

- [ ] Anxiety or tension
- [ ] Insomnia
- [ ] Irritability or easily become angry
- [ ] Hyperactivity or restlessness
- [ ] Eyes hurt with oncoming light
- [ ] Severe or Recurrent stress
- [ ] Low body temperature, always feel cold
- [ ] Food or other allergies
- [ ] Poor concentration or memory
- [ ] Tendency to depression or feeling low
- [ ] Aggressiveness
- [ ] Dizzy on standing
- [ ] Craving salty foods
- [ ] Slow recovery from stress
- [ ] PMS or low sex drive
- [ ] Extreme exhaustion

- [ ] Lack of energy
- [ ] Depression or feeling low
- [ ] Cold hands or feet
- [ ] Hair loss
- [ ] Insomnia
- [ ] Weight control problems
- [ ] Constipation
- [ ] Dry or thickening skin
- [ ] Transverse grooves or brittle nails
- [ ] Menstrual problems or PMS

- [ ] Eczema or dermatitis
- [ ] Dry, flaky or itchy skin
- [ ] Acne
- [ ] Pale skin
- [ ] Bleeding or tender gums
- [ ] Stretch marks
- [ ] Peeling, soft or splitting nails
- [ ] Hair loss or poor condition
- [ ] Rings round the eyes or puffy eyes
- [ ] Poor sense of taste or smell
- [ ] Psoriasis
- [ ] Hives
- [ ] Rosacea
- [ ] Ageing skin
- [ ] Mouth ulcers
- [ ] 2 or more white marks on nails
- [ ] Dandruff
- [ ] Sore tongue
- [ ] Hot flushes or night sweats
- [ ] Strong body odour

- [ ] Muscle aches, cramps or spasm
- [ ] Low bone density
- [ ] Osteoarthritis or Rheumatoid arthritis
- [ ] Gout
- [ ] Muscle weakness
- [ ] Joint pain or stiffness
- [ ] Osteopenia or osteoporosis
- [ ] Back pain
- [ ] Fractures
- [ ] Kidney stones

**For Women Only**

Are you pregnant? If so, how many weeks? …….

Are you trying to become pregnant? …….

Are you having difficulty conceiving? ……..

Are you undergoing fertility treatment? ……

Do you have an IUD fitted? State which ……...

Do you use the contraceptive pill? State which …….

Are your periods regular? _____ Are your periods heavy or painful? _____

Do you suffer from Pre-menstrual syndrome (PMS)?

***Circle the symptom*(s): fatigue, anxiety, nervoious tension, irritability, mood swings, sweet craving, increased appetite, bloating, breast tenderness, depression, other**

Are you menopausal or post menopausal? ……..

How long ago was your last period? ……

Are you taking hormone replacement therapy (HRT)? _____

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In addition to filling in the **food diary**, please answer the following questions:

**How many times a week do you eat or drink:**

Live yoghurt ____ Salads ____

Raw vegetables ____ Processed meats (salami, sausages, hamburgers etc.)____

Ham/bacon ____ Red meat (beef, lamb, pork) ____

Chicken ____ Seeds (sunflower, pumpkin, sesame etc) ____

Oily fish (salmon, tuna, mackerel, sardines, anchovies, herring) ____

Other fish ____ Eggs ____

Chocolate ____ other confectionary ____

Cakes/biscuits ____ other foods containing sugar ____

Pasta ____ (white / whole-wheat / non-wheat, ***please circle which***)

Breakfast cereals ____

***State which*** _____

Cheese ____ Rice ____ State type i.e. white, brown ____

Fried foods ____ canned food ____

Home cooked meals ____ Ready meals ____ Eat out ____

Take away ____

***Please specify*** _____

**How much of the following do you eat/drink in a day**

Fresh fruit ____ portions  Vegetables (not including potatoes) ____ portions

Slices of bread/rolls ____ State type e.g. white, wholemeal, French _____

Milk ____ pint of cow's whole / semi-skimmed / skimmed (***circle***) or other

Coffee ____ cups or mugs  Tea ____ cups or mugs

Water ____ glasses of tap, bottled, filtered (***circle***)  Alcohol ____ glasses. State type _____

Fizzy drinks _____ State type _____  Sugar ____ teaspoons

**Other Questions**

Do you use salt in your cooking? Yes/No/Sometimes

Do you add salt to your food? Yes/No/Sometimes

Do you wash fruit and vegetables before eating? Yes/No/Sometimes

Do you eat organic food? Yes/No/Sometimes

***State type*** _____

***Please list*** the five foods you most like

_____

***Please list*** the five foods you most dislike

_____

Do you miss meals? Yes/No/Sometimes  If so which _____

Do you enjoy food preparation? Yes/No/Sometimes

***Please circle*** any of the following ways you prepare food

Grill  Bake  Fry  Stir fry  Microwave  Boil  Raw  Ready meals

Do you eat under stressful conditions or on the move? Yes/No/Sometimes

How would you describe your appetite? Poor / average / good (***circle***)

Is your diet based on any religious rules? ____ ***Please specify*** _____

***Please circle*** any of the following special diets you are on now

Vegetarian (but eat fish),  Vegetarian (no fish),  Vegan,  Gluten free,  Diabetic,  Low cholesterol,