



Nutritional Programme Questionnaire

PART ONE

Title _____ Name _____ Date of Birth _____ Age _____

Address _____

Postcode _____ Tel (Home) _____ (Work) _____

(Mobile) _____ Email _____

Occupation (please give brief details of what your day involves) _____

Measurements: Weight _____ Height _____ Waist _____

Health Problems

Please list your health problems. **Number 1 should be the main problem you want to address.**

Health Problem	Duration
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

Under what circumstances do these problems improve? _____

Under what circumstances do they get worse? _____

What other illnesses have you had in the past (including childhood)? Approx when? _____

What operations have you had? Approx when? _____

What drugs do you take (including painkillers)? State dosage _____

What is your normal blood pressure (if known)? _____ Resting pulse rate per minute? _____

GP/Consultant name and address? _____

Hereditary Profile

State gender and age of any children _____

State gender and age of brothers/sisters _____

Do they suffer from any illnesses? _____

What illnesses is/was your father prone to? _____

What illnesses is/was your mother prone to? _____

PART TWO

Read the following questions and fill in the number that applies:

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: 0 (or leave blank) = No or Do not have the symptom, the symptom does not occur
 1 = Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
 2 = It is a moderate symptom or it occasionally occurs (weekly)
 3 = It is a severe symptom or it frequently occurs (daily)

Section 1 – Upper Gastrointestinal System

- | | |
|---|--|
| <input type="checkbox"/> Belching or gas within 1 hr. of a meal
<input type="checkbox"/> Heartburn or acid reflux
<input type="checkbox"/> Bloating shortly after eating
<input type="checkbox"/> Are you a vegan (no dairy, meat, fish or eggs)
<input type="checkbox"/> Bad breath (halitosis)
<input type="checkbox"/> Loss of taste for meat
<input type="checkbox"/> Sweat has a strong odor
<input type="checkbox"/> Stomach upset by taking vitamins
<input type="checkbox"/> Sense of excess fullness after meals | <input type="checkbox"/> Do you feel like skipping breakfast?
<input type="checkbox"/> Do you feel better if you don't eat?
<input type="checkbox"/> Sleepy after meals
<input type="checkbox"/> Fingernails chip, peel or break easily
<input type="checkbox"/> Anemia unresponsive to iron
<input type="checkbox"/> Stomach pains or cramps
<input type="checkbox"/> Diarrhea, chronic
<input type="checkbox"/> Diarrhea shortly after meals
<input type="checkbox"/> Black or tarry stools
<input type="checkbox"/> Undigested food in stool |
|---|--|

Section 2 – Liver and Gallbladder

- | | |
|---|--|
| <input type="checkbox"/> Pain between shoulder blades
<input type="checkbox"/> Stomach upset by greasy foods
<input type="checkbox"/> Greasy or shiny stools
<input type="checkbox"/> Nausea
<input type="checkbox"/> Sea, car or airplane sickness, motion sickness
<input type="checkbox"/> History of morning sickness (1 = yes, 0 = no)
<input type="checkbox"/> Light or clay colored stools
<input type="checkbox"/> Dry skin, itchy feet and/or skin peels on feet
<input type="checkbox"/> Headache over the eye
<input type="checkbox"/> Gallbladder attacks (past or present)
<input type="checkbox"/> Gallbladder removed (1 = yes, 0 = no)
<input type="checkbox"/> Bitter taste in mouth, especially after meals
<input type="checkbox"/> Become sick if drinking wine
<input type="checkbox"/> If drinking alcohol, easily intoxicated | <input type="checkbox"/> Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
<input type="checkbox"/> Recovering alcoholic (1 = yes, 0 = no)
<input type="checkbox"/> Hangovers after drinking alcohol
<input type="checkbox"/> History of drug or alcohol abuse (1 = yes, 0 = no)
<input type="checkbox"/> History of hepatitis (1 = yes, 0 = no)
<input type="checkbox"/> Long term use of prescription medications (1 = yes, 0 = no)
<input type="checkbox"/> Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
<input type="checkbox"/> Sensitive to tobacco smoke
<input type="checkbox"/> Exposure to diesel fumes
<input type="checkbox"/> Pain under right side of rib cage
<input type="checkbox"/> Hemorrhoids or varicose veins
<input type="checkbox"/> Nutrasweet (aspartame) consumption
<input type="checkbox"/> Bothered by aspartame (NutraSweet)
<input type="checkbox"/> Chronic fatigue or Fibromyalgia |
|---|--|

Section 3 – Small Intestine

- | | |
|--|---|
| <input type="checkbox"/> Food allergies
<input type="checkbox"/> Abdominal bloating 1 to 2 hours after eating
<input type="checkbox"/> Specific foods make you tired or bloated (1 = yes, 0 = no)
<input type="checkbox"/> Pulse speeds after eating
<input type="checkbox"/> Airborne allergies
<input type="checkbox"/> Experience hives
<input type="checkbox"/> Sinus congestion, "stuffy head"
<input type="checkbox"/> Crave bread or noodles
<input type="checkbox"/> Alternating constipation and diarrhea | <input type="checkbox"/> Crohn's disease (1 = yes, 0 = no)
<input type="checkbox"/> Wheat or grain sensitivity
<input type="checkbox"/> Dairy sensitivity
<input type="checkbox"/> Are there foods you could not give up (1 = yes, 0 = no)
<input type="checkbox"/> Asthma, sinus infections, stuffy nose
<input type="checkbox"/> Bizarre vivid or nightmarish dreams
<input type="checkbox"/> Use over-the-counter pain medications
<input type="checkbox"/> Feel spacey or unreal |
|--|---|

Section 4 – Large Intestine

- | | |
|---|--|
| <input type="checkbox"/> Anus itches
<input type="checkbox"/> Coated tongue
<input type="checkbox"/> Feel worse in moldy or musty place
<input type="checkbox"/> Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
<input type="checkbox"/> Fungus or yeast infections
<input type="checkbox"/> Ring worm, "jock itch", "athletes foot", nail fungus
<input type="checkbox"/> Eating sugar, starch or drinking alcohol increases yeast symptoms
<input type="checkbox"/> Stools hard or difficult to pass
<input type="checkbox"/> History of parasites (1 = yes, 0 = no) | <input type="checkbox"/> Less than one bowel movement per day
<input type="checkbox"/> Stools have corners or edges are flat or ribbon shaped
<input type="checkbox"/> Stools are not well formed (loose)
<input type="checkbox"/> Irritable bowel or mucus colitis
<input type="checkbox"/> Blood in stool
<input type="checkbox"/> Mucus in stool
<input type="checkbox"/> Excessive foul smelling lower bowel gas
<input type="checkbox"/> Bad breath or strong body odors
<input type="checkbox"/> Painful to press along outer sides of thighs (Iliotibial Band)
<input type="checkbox"/> Cramping in lower abdominal region
<input type="checkbox"/> Dark circles under eyes |
|---|--|

Section 5 – Mineral Needs

- | | |
|--|--|
| <input type="checkbox"/> History of Carpal Tunnel Syndrome (1 = yes, 0 = no) | <input type="checkbox"/> Morning stiffness |
| <input type="checkbox"/> History of lower right abdominal pain (1 = yes, 0 = no) | <input type="checkbox"/> Vomiting or nausea |
| <input type="checkbox"/> History of stress fractures | <input type="checkbox"/> Crave chocolate |
| <input type="checkbox"/> Bone loss (reduced density on bone scan) | <input type="checkbox"/> Feet have a strong odor |
| <input type="checkbox"/> Are you shorter than you used to be? (1 = yes, 0 = no) | <input type="checkbox"/> Tendency to anemia |
| <input type="checkbox"/> Calf, foot or toe cramps at rest | <input type="checkbox"/> Whites of eyes (sclera) blue tinted |
| <input type="checkbox"/> Cold sores, fever blisters or herpes lesions | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Frequent fevers | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Frequent skin rashes and / or hives | <input type="checkbox"/> Lump in throat |
| <input type="checkbox"/> Have you ever had a herniated disc? (1 = yes, 0 = no) | <input type="checkbox"/> Dry mouth, eyes and / or nose |
| <input type="checkbox"/> Excessively flexible joints, "double jointed" | <input type="checkbox"/> Gag easily |
| <input type="checkbox"/> Joints pop or click | <input type="checkbox"/> White spots on fingernails |
| <input type="checkbox"/> Pain or swelling in joints | <input type="checkbox"/> Cuts heal slowly and / or scar easily |
| <input type="checkbox"/> Bursitis or tendonitis | <input type="checkbox"/> Decreased sense of taste or smell |
| <input type="checkbox"/> History of bone spurs (1 = yes, 0 = no) | |

Section 6 – Essential Fatty Acids

- | | |
|--|---|
| <input type="checkbox"/> Aspirin is an effective pain reliever (1 = yes, 0 = no) | <input type="checkbox"/> Headaches when out in the hot sun |
| <input type="checkbox"/> Crave fatty or greasy foods | <input type="checkbox"/> Sunburn easily or suffer sun poisoning |
| <input type="checkbox"/> Low or reduced fat diet (past or present) | <input type="checkbox"/> Muscles easily fatigued |
| <input type="checkbox"/> Tension headaches at base of skull | <input type="checkbox"/> Dry flaky skin and or dandruff |

Section 7 – Sugar Handling

- | | |
|---|---|
| <input type="checkbox"/> Awaken a few hours after falling asleep, hard to get back to sleep | <input type="checkbox"/> Fatigue that is relieved by eating |
| <input type="checkbox"/> Crave sweets | <input type="checkbox"/> Headache if meals are skipped or delayed |
| <input type="checkbox"/> Eat desserts or sugary snacks | <input type="checkbox"/> Irritable before meals |
| <input type="checkbox"/> Binge or uncontrolled eating | <input type="checkbox"/> Shaky if meals delayed |
| <input type="checkbox"/> Excessive appetite | <input type="checkbox"/> Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4) |
| <input type="checkbox"/> Crave coffee or sugar in the afternoon | <input type="checkbox"/> Frequent thirst |
| <input type="checkbox"/> Sleepy in afternoon | <input type="checkbox"/> Frequent urination |

Section 8 – Vitamin Need

- | | |
|--|---|
| <input type="checkbox"/> Muscles become easily fatigued | <input type="checkbox"/> Can hear heart beat on pillow at night |
| <input type="checkbox"/> Feel worse, sore after moderate exercise | <input type="checkbox"/> Whole body or limb jerk as falling asleep |
| <input type="checkbox"/> Vulnerable to insect bites | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> Loss of muscle tone, heaviness in arms / legs | <input type="checkbox"/> Restless leg syndrome |
| <input type="checkbox"/> Enlarged heart, or heart failure | <input type="checkbox"/> Cheilosis (cracks at corner of mouth) |
| <input type="checkbox"/> Pulse slow / below 65 (1 = yes, 0 = no) | <input type="checkbox"/> Fragile skin, easily chaffed, as in shaving |
| <input type="checkbox"/> Ringing in the ears / Tinnitus | <input type="checkbox"/> Polyps or warts |
| <input type="checkbox"/> Numbness, tingling or itching in extremities | <input type="checkbox"/> MSG sensitivity |
| <input type="checkbox"/> Depressed | <input type="checkbox"/> Wake up without remembering dreams |
| <input type="checkbox"/> Fear of impending doom | <input type="checkbox"/> Take birth control pills |
| <input type="checkbox"/> Worrier, apprehensive, anxious | <input type="checkbox"/> Small bumps on back of arms |
| <input type="checkbox"/> Nervous or agitated | <input type="checkbox"/> Strong light at night irritates eyes |
| <input type="checkbox"/> Feelings of insecurity | <input type="checkbox"/> Nose bleeds and / or tend to bruise easily |
| <input type="checkbox"/> Heart races | <input type="checkbox"/> Bleeding gums especially when brushing teeth |

Section 9 – Adrenal

- | | |
|--|---|
| <input type="checkbox"/> Tend to be a "night person" | <input type="checkbox"/> Arthritic tendencies |
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Crave salty foods |
| <input type="checkbox"/> Slow starter in the morning | <input type="checkbox"/> Salt foods before tasting |
| <input type="checkbox"/> Keyed up, trouble calming down | <input type="checkbox"/> Perspire easily |
| <input type="checkbox"/> High blood pressure (normal 120/80) | <input type="checkbox"/> Chronic fatigue, or get drowsy often |
| <input type="checkbox"/> Headache after exercising | <input type="checkbox"/> Afternoon yawning |
| <input type="checkbox"/> Feeling wired or jittery if drinking coffee | <input type="checkbox"/> Afternoon headache |
| <input type="checkbox"/> Clench or grind teeth | <input type="checkbox"/> Asthma, wheezing or difficulty breathing |
| <input type="checkbox"/> Calm on the outside, troubled inside | <input type="checkbox"/> Pain on the medial or inner side of the knee |
| <input type="checkbox"/> Chronic low back pain, worse with fatigue | <input type="checkbox"/> Tendency to sprain ankles or "shin splints" |
| <input type="checkbox"/> Become dizzy when standing up suddenly | <input type="checkbox"/> Tendency to need to wear sunglasses |
| <input type="checkbox"/> Difficult maintaining manipulative correction | <input type="checkbox"/> Allergies and / or hives |
| <input type="checkbox"/> Pain after manipulative correction | <input type="checkbox"/> Weakness, dizziness |

Section 10 – Pituitary

- | | |
|---|--|
| <input type="checkbox"/> Over 6' 6" tall (Mature height) | <input type="checkbox"/> Under 4' 10" (Mature height) |
| <input type="checkbox"/> Early sexual development (before age 10) (1 = yes, 0 = no) | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Increased libido | <input type="checkbox"/> Abnormal thirst |
| <input type="checkbox"/> Splitting type headache | <input type="checkbox"/> Weight gain around hips or waist |
| <input type="checkbox"/> Memory failing | <input type="checkbox"/> Menstrual disorders |
| <input type="checkbox"/> Ability to tolerate sugar | <input type="checkbox"/> Delayed (after age 13) sexual development (1 = yes, 0 = no) |
| | <input type="checkbox"/> Tendency to ulcers or colitis |

Section 11 – Thyroid

- | | |
|--|--|
| <input type="checkbox"/> Allergic to iodine | <input type="checkbox"/> Mentally sluggish, reduced initiative |
| <input type="checkbox"/> Difficulty gaining weight, even with large appetite | <input type="checkbox"/> Easily fatigued, sleepy during the day |
| <input type="checkbox"/> Nervous, emotional, can't work under pressure | <input type="checkbox"/> Sensitive to cold, poor circulation (cold hands and feet) |
| <input type="checkbox"/> Inward trembling | <input type="checkbox"/> Constipation, chronic |
| <input type="checkbox"/> Flush easily | <input type="checkbox"/> Excessive hair loss and / or coarse hair |
| <input type="checkbox"/> Fast pulse at rest | <input type="checkbox"/> Morning headaches, wear off during the day |
| <input type="checkbox"/> Intolerance to high temperatures | <input type="checkbox"/> Loss of lateral 1/3 of eyebrow |
| <input type="checkbox"/> Difficulty losing weight | <input type="checkbox"/> Seasonal sadness |

Section 12 – Men Only

- | | |
|---|--|
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Waking to urinate at night |
| <input type="checkbox"/> Urination difficult or dribbling | <input type="checkbox"/> Interruption of stream during urination |
| <input type="checkbox"/> Difficult to start and stop urine stream | <input type="checkbox"/> Pain on inside of legs or heels |
| <input type="checkbox"/> Pain or burning with urination | <input type="checkbox"/> Feeling of incomplete bowel evacuation |
| | <input type="checkbox"/> Decreased sexual function |

Section 13 – Women Only

- | | |
|--|---|
| <input type="checkbox"/> Depression during periods | <input type="checkbox"/> Breast fibroids, benign masses |
| <input type="checkbox"/> Mood swings associated with periods (PMS) | <input type="checkbox"/> Painful intercourse (dyspareunia) |
| <input type="checkbox"/> Crave chocolate around periods | <input type="checkbox"/> Vaginal discharge |
| <input type="checkbox"/> Breast tenderness associated with cycle | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Excessive menstrual flow | <input type="checkbox"/> Vaginal itchiness |
| <input type="checkbox"/> Scanty blood flow during periods | <input type="checkbox"/> Gain weight around hips, thighs and buttocks |
| <input type="checkbox"/> Occasional skipped periods | <input type="checkbox"/> Excess facial or body hair |
| <input type="checkbox"/> Variations in menstrual cycles | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Night sweats (in menopausal females) |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> Thinning skin |

Section 14 – Cardiovascular

- | | |
|--|---|
| <input type="checkbox"/> Aware of heavy and / or irregular breathing | <input type="checkbox"/> Ankles swell, especially at end of day |
| <input type="checkbox"/> Discomfort at high altitudes | <input type="checkbox"/> Cough at night |
| <input type="checkbox"/> "Air hunger" and / or yawn frequently | <input type="checkbox"/> Blush or face turns red for no reason |
| <input type="checkbox"/> Compelled to open windows in a closed room | <input type="checkbox"/> Dull pain or tightness in chest and / or radiate into right arm, worse with exertion |
| <input type="checkbox"/> Shortness of breath with moderate exertion | <input type="checkbox"/> Muscle cramps with exertion |

Section 15 – Kidney and Bladder

- | | |
|--|---|
| <input type="checkbox"/> Pain in mid back region | <input type="checkbox"/> Cloudy, bloody or darkened urine |
| <input type="checkbox"/> Dark circles under eyes and / or puffy eyes | <input type="checkbox"/> Urine has a strong odor |
| <input type="checkbox"/> History of kidney stones (1 = yes, 0 = no) | |

Section 16 – Immune system

- | | |
|--|--|
| <input type="checkbox"/> Runny or drippy nose | <input type="checkbox"/> Acne (adult) |
| <input type="checkbox"/> Catch colds at the beginning of winter | <input type="checkbox"/> Itchy skin / dermatitis |
| <input type="checkbox"/> Mucus producing cough | <input type="checkbox"/> Cysts, boils, rashes |
| <input type="checkbox"/> Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.) | <input type="checkbox"/> History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no) |
| <input type="checkbox"/> Frequent colds or flu | |
| <input type="checkbox"/> Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.) | |



PART THREE: Diet Analysis

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to.

- | | |
|--|---|
| <input type="checkbox"/> Were you breast fed? | <input type="checkbox"/> Do you wash fruit and veg before eating? |
| <input type="checkbox"/> Was a significant percentage of your diet as a child high in fatty foods? | <input type="checkbox"/> Do you normally eat white rice / flour? |
| <input type="checkbox"/> Do you go out of your way to avoid foods containing preservatives or additives? | <input type="checkbox"/> How many cans of food do you eat a week? |
| <input type="checkbox"/> Do you avoid foods that contain sugar? | <input type="checkbox"/> How many slices of bread or rolls do you eat a wk? |
| <input type="checkbox"/> How many teaspoons of sugar do you add to your food / drinks each day? | <input type="checkbox"/> How many pints of milk do you drink a week? |
| <input type="checkbox"/> Do you use salt in your cooking? | <input type="checkbox"/> How many times a week do you eat red meat? |
| <input type="checkbox"/> Do you add salt to your food? | <input type="checkbox"/> How many times a week to you eat white meat? |
| <input type="checkbox"/> How many coffees do you drink each day? | <input type="checkbox"/> How many times a week do you eat fish? |
| <input type="checkbox"/> How many cups of tea do you drink each day? | <input type="checkbox"/> What is you usual alcoholic drink? _____ |
| <input type="checkbox"/> How many times a week do you eat fried food? | <input type="checkbox"/> How many glasses of alcohol do you drink a week? |
| <input type="checkbox"/> How many times a week do you eat ready meals? | <input type="checkbox"/> How many times a week do you eat live yoghurt? |
| <input type="checkbox"/> How many times a week do you eat take away/fast food? | <input type="checkbox"/> Do you drink bottled/filtered water instead of tap water? |
| <input type="checkbox"/> How many times a week do you eat chocolate/sweets? | <input type="checkbox"/> Do you frequently eat under stressful conditions or on the move? |
| <input type="checkbox"/> What percentage of your diet is raw fruit and veg? | <input type="checkbox"/> How many glasses/litres of water do you drink each day? |
| | <input type="checkbox"/> Do you often eat out socially or with work? |
| | <input type="checkbox"/> Is your appetite? a) good b) average c)poor |

4 Day Food Diary

Day One	Day Two
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks/drinks	Snacks/drinks
Day Three	Day Four
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks/drinks	Snacks/drinks

How did you find out about Healthy Approach? _____

Please list any supplements you currently take: _____

Terms of Engagement between the Nutritional Therapist & the Client

Please read the points below and sign the agreement. Please return this with your questionnaire, or bring along with you to your consultation.

1. Nutritional therapists are not permitted to diagnose or claim to treat any medical condition. Nutritional advice is not a substitute for professional medical treatment. The aim of nutritional therapy is to provide optimum nourishment and support to the body to facilitate it's own self-healing mechanisms.
2. The suitability of the nutritional advice you are given depends to a large extent on the accuracy with which you complete the questionnaire and food diary (though clarifications may be made during the consultation). Please complete the questionnaire as fully as possible. In particular you should include details of pre-diagnosed medical conditions and any medications you are taking. Please inform your therapist immediately if there is a change in your diagnosis or medication whilst you are following your nutritional programme.
3. The benefits achievable from nutritional therapy vary between individuals with similar health concerns, following similar nutritional therapy programmes. The results you obtain from your nutritional programme will also depend upon your degree of adherence to the advice given.
4. The advice of your nutritional therapist is tailored to support medically established, diagnosed conditions and/or health concerns identified and agreed between you and your therapist. You are responsible for contacting your doctor with regard to any health concerns you may have and you are advised to do so in all instances of ill health.
5. If you are receiving treatment from your GP, other medical consultant, or an alternative healthcare professional you are advised to inform them of your nutritional programme in order to rule out the possibility of contraindications between different practices. If you are on medication you should immediately inform your doctor of your nutritional programme.
6. Please do not modify your nutritional programme on the advice of a third party, without prior discussion with your nutritional therapist.
7. To avoid adverse reactions it is important that you do not continue your nutritional programme beyond the agreed period.
8. Your nutritional therapist adheres to the Code of Ethics and Practice and the Standards of Practice in the profession of nutritional therapy as governed by the British Association for Applied Nutrition and Nutritional Therapy (BANT). BANT may be contacted at 27 Old Gloucester Street, London, WC1N 3XX (tel 08706 061 284) or at <http://www.bant.org.uk>.

I understand the above and agree that our professional relationship will be based on the content of this document.

Signed by the Client: **Date:**

Please print name:

Signed by the Therapist: **Date:**