Please return your completed questionnaire either by email to info@healthyapproach.co.uk or by post to **Healthy Approach, 35 Melton Road, Leamington Spa, CV32 7DJ** – please note that this is a postal address only and is NOT where you will have your consultation. If you are unable to return your questionnaire in advance, then please remember to bring it with you to your consultation at the **Traditional Acupuncture Centre, 19 Binswood St, Leamington Spa, CV32 5RW**.

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?_____

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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

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

Section 2 – Liver and Gallbladder

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

Section 3 – Small Intestine

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

Section 4 – Large Intestine

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

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Section 5 – Mineral Needs

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

Section 6 – Essential Fatty Acids

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

Section 7 – Sugar Handling

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

Section 8 – Vitamin Need

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

Section 9 – Adrenal

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

Section 10 – Pituitary

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

Section 11 – Thyroid

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

Section 12 – Men Only

_____ Prostate problems
_____ Urination difficult or dribbling
_____ Difficult to start and stop urine stream
_____ Pain or burning with urination
_____ Waking to urinate at night
_____ Interruption of stream during urination
_____ Pain on inside of legs or heels
_____ Feeling of incomplete bowel evacuation
_____ Decreased sexual function

Section 13 – Women Only

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

Section 14 – Cardiovascular

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

Section 15 – Kidney and Bladder

_____ Pain in mid back region
_____ Dark circles under eyes and / or puffy eyes
_____ History of kidney stones (1 = yes, 0 = no)
_____ Cloudy, bloody or darkened urine
_____ Urine has a strong odor

Section 16 – Immune system

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

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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.

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

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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 partly 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. Your nutritional therapist may recommend food supplements and/or functional testing as part of your nutritional therapy programme and may receive a commission on these products or services.

7. Please do not modify your nutritional programme on the advice of a third party, without prior discussion with your nutritional therapist.

8. To avoid adverse reactions it is important that you do not continue your nutritional programme beyond the agreed period. Contact your nutritional therapist if you wish to continue a supplement programme for longer than the original agreed period.

9. 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: ……