

CLIENT QUESTIONNAIRE

THIS DOCUMENT IS HELD IN THE STRICTEST CONFIDENCE

Please answer all the questions as fully as you are able or discuss with your practitioner during the consultation.

First name: _____ **Last name:** _____

Address: _____

Post Code: _____ **e-mail:** _____

Tel no: _____ **Daytime:** _____

Date of Birth: _____ **Occupation:** _____

Height: _____ **Weight:** _____

Blood pressure: _____ **Resting Pulse:** _____ **Blood Group:** _____

Have you been diagnosed with (delete if not applicable): Cancer/Diabetes/Epilepsy/HIV or AIDS

Reasons for consultation (inc. current health problems and their duration):

if necessary, please continue on a separate sheet

List all medications you are presently taking and for how long:

Doctor's contact details (if applicable): _____

List any herbal medicines or nutritional supplements you are presently taking:

Have you had any health problems/hospitalisations in the past (including childhood)? What and when?

FAMILY HISTORY:

What illnesses have your parents or grandparents suffered from? _____

Do you have any brothers or sisters (state age and sex)? _____

Do they suffer from any particular illnesses? _____

Do you have any children (state age and sex)? _____

Please tick all those that apply and underline symptom if appropriate

DENTAL HEALTH PROFILE		EXERCISE PROFILE	
<input type="checkbox"/>	See the dentist regularly	<input type="checkbox"/>	State what weekly exercise you do. Is it light, moderate or strenuous?
<input type="checkbox"/>	Have amalgam or gold fillings	<input type="checkbox"/>	
<input type="checkbox"/>	Have any root canals	<input type="checkbox"/>	
<input type="checkbox"/>	Suffer from bleeding gums or other dental disease	<input type="checkbox"/>	
<input type="checkbox"/>	Mouth ulcers	<input type="checkbox"/>	
DIGESTIVE HEALTH PROFILE			
<input type="checkbox"/>	Chew food thoroughly	<input type="checkbox"/>	Blood in stool or black or tarry coloured stools
<input type="checkbox"/>	Use antacids	<input type="checkbox"/>	Pale, fatty or greasy stools
<input type="checkbox"/>	Burning in stomach relieved by eating or history of ulcers	<input type="checkbox"/>	Difficulty digesting particular foods?
<input type="checkbox"/>	Belching or heartburn	<input type="checkbox"/>	What? _____
<input type="checkbox"/>	Abdominal bloating shortly after eating	<input type="checkbox"/>	Food cravings? What? _____
<input type="checkbox"/>	Abdominal bloating 1 to 2 hours after eating	<input type="checkbox"/>	Foods cause fatigue/bloating? What? _____
<input type="checkbox"/>	Sense of excessive fullness after meals	<input type="checkbox"/>	_____
<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	Lower right abdominal pain
<input type="checkbox"/>	Tongue coating. What colour? _____	<input type="checkbox"/>	Diarrhoea shortly after meals
<input type="checkbox"/>	Loss of taste for meat	<input type="checkbox"/>	Sinus congestion, stuffy nose, stuffy head (<i>please underline</i>)
<input type="checkbox"/>	Stomach easily upset (by certain foods, supplements etc.)	<input type="checkbox"/>	Nasal drip/runny nose/sneezing after meals (<i>please underline</i>)
<input type="checkbox"/>	Decreased sense of taste or smell	<input type="checkbox"/>	Catarrh
<input type="checkbox"/>	Do you feel better for not eating?	<input type="checkbox"/>	Food poisoning. When? _____
<input type="checkbox"/>	Do you feel like skipping breakfast?	<input type="checkbox"/>	Headache over the eye
<input type="checkbox"/>	Stomach pains or cramps	<input type="checkbox"/>	Difficulty digesting fatty foods
<input type="checkbox"/>	Lower abdominal pain or cramps	<input type="checkbox"/>	Gallbladder attacks or gallbladder removed
<input type="checkbox"/>	Constipation (less than one bowel movement per day)	<input type="checkbox"/>	Bitter or metallic taste in mouth, especially after meals
<input type="checkbox"/>	Diarrhoea	<input type="checkbox"/>	Nausea/Vomiting
<input type="checkbox"/>	Flatulence	<input type="checkbox"/>	Pain under right side of rib cage
<input type="checkbox"/>	Undigested food in stool	<input type="checkbox"/>	Pain between shoulder blades
<input type="checkbox"/>	Mucous in stool	<input type="checkbox"/>	Itchy feet/peeling skin on feet/cracked heels (<i>underline</i>)
<input type="checkbox"/>	Stools hard and difficult to pass/or small 'rabbit droppings'	<input type="checkbox"/>	A feeling of incomplete evacuation
<input type="checkbox"/>	Stools are not well formed (loose stools)	<input type="checkbox"/>	Anal irritation/Haemorrhoids (piles)
<input type="checkbox"/>	Stools have a foul odour	<input type="checkbox"/>	Frequent use of antibiotics
DETOXIFICATION PROFILE			
<input type="checkbox"/>	History of alcohol or drug abuse	<input type="checkbox"/>	Yellow discolouration of eyes/skin
<input type="checkbox"/>	Hangover after drinking alcohol or easily intoxicated	<input type="checkbox"/>	History of morning sickness
<input type="checkbox"/>	Become sick if drinking wine	<input type="checkbox"/>	Adverse reaction to sulphite food additives
<input type="checkbox"/>	History of smoking	<input type="checkbox"/>	Eating asparagus results in strong urine odour
<input type="checkbox"/>	History of prescribed medications	<input type="checkbox"/>	Rapid metabolism of caffeine (drink 2 cups at night & sleep well)
<input type="checkbox"/>	Exposure to environmental toxins (workplace, traffic etc.)	<input type="checkbox"/>	Bizarre, vivid or nightmarish dreams
<input type="checkbox"/>	Sensitive to chemicals (perfumes, cleaning fluids, exhaust etc.)	<input type="checkbox"/>	Pain in mid-back region
<input type="checkbox"/>	Sensitive to tobacco smoke	<input type="checkbox"/>	Dark circles under eyes or puffy eyes
<input type="checkbox"/>	Feet have a strong odour	<input type="checkbox"/>	History of kidney stones
<input type="checkbox"/>	Reduced sweating/Never sweat	<input type="checkbox"/>	Cystitis
<input type="checkbox"/>	MSG sensitivity	<input type="checkbox"/>	Cloudy, bloody or dark urine
<input type="checkbox"/>	Travel or motion sickness	<input type="checkbox"/>	Urine has strong odour
<input type="checkbox"/>	Unexplained skin itching	<input type="checkbox"/>	Facial puffiness/Fluid retention (<i>please underline</i>)
BLOOD SUGAR		ADRENALS	
<input type="checkbox"/>	Fatigue/apathy	<input type="checkbox"/>	Too tired to exercise/symptoms aggravated by exercise
<input type="checkbox"/>	Drowsy during the day. When? _____	<input type="checkbox"/>	Worrier, apprehensive, anxious
<input type="checkbox"/>	Headaches. Describe: _____	<input type="checkbox"/>	Slow starter in the morning/gaining energy as day goes on
<input type="checkbox"/>	Mood swings or energy highs and lows	<input type="checkbox"/>	Afternoon yawning/drowsiness
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Awake a few hours after falling asleep, hard to get back to sleep
<input type="checkbox"/>	Poor memory or poor concentration	<input type="checkbox"/>	Difficulty falling asleep
<input type="checkbox"/>	Binge or uncontrolled eating	<input type="checkbox"/>	Keyed up, trouble in calming down
<input type="checkbox"/>	Craving for sweets or carbohydrates	<input type="checkbox"/>	Headaches after exercising
<input type="checkbox"/>	Need coffee/tea to get started in the morning	<input type="checkbox"/>	Feeling wired or jittery if drinking coffee
<input type="checkbox"/>	Dizzy/irritable/shaky if meals delayed (<i>please underline</i>)	<input type="checkbox"/>	Clenching or grinding teeth
<input type="checkbox"/>	Night sweats/Profuse sweating (<i>please underline</i>)	<input type="checkbox"/>	Become dizzy when standing up suddenly
<input type="checkbox"/>	Sleepy after meals	<input type="checkbox"/>	Crave salty foods/Need snacks or stimulants to keep going
<input type="checkbox"/>	Get very thirsty	<input type="checkbox"/>	Chronic low back pain, worse with fatigue
<input type="checkbox"/>	Need to urinate frequently	<input type="checkbox"/>	Sensitive to bright lights/sunlight

DIETARY ANALYSIS

<input type="checkbox"/>	Are you a vegan or vegetarian?	<input type="checkbox"/>	Do you have at least 5 portions of salad/vegetables a day?
<input type="checkbox"/>	Do you eat out a lot? Times per week? _____	<input type="checkbox"/>	Do you eat fruit? Pieces per day _____
<input type="checkbox"/>	Do you eat on the run or whilst working?	<input type="checkbox"/>	How many times a week do you have:
<input type="checkbox"/>	How much water do you drink daily? _____	<input type="checkbox"/>	Fried or barbecued food?
<input type="checkbox"/>	Is the water you drink: filtered/bottle/tap (<i>please underline</i>)	<input type="checkbox"/>	Stir-fried food
<input type="checkbox"/>	Would you say you had a 'good' appetite?	<input type="checkbox"/>	Red meat?
<input type="checkbox"/>	Are you constantly hungry?	<input type="checkbox"/>	Poultry?
<input type="checkbox"/>	Do you eat organic food as much as possible?	<input type="checkbox"/>	White Fish
<input type="checkbox"/>	Do you eat refined food (e.g. white bread, cereals, baked goods)?	<input type="checkbox"/>	Oily fish
<input type="checkbox"/>	Do you eat foods which contain sugar?	<input type="checkbox"/>	Packet and takeaway meals
<input type="checkbox"/>	Do you add sugar to food/drinks?	<input type="checkbox"/>	Do you eat live yoghurt?
<input type="checkbox"/>	Do you use artificial sweeteners?	<input type="checkbox"/>	Do you drink cow's milk? How much a week? _____
<input type="checkbox"/>	Do you add salt to food (or in cooking)?	<input type="checkbox"/>	How many slices of bread/rolls do you eat a week? _____
<input type="checkbox"/>	Do you drink coffee? How many per day? _____	<input type="checkbox"/>	Do you eat hydrogenated fats? (<i>e.g. crisps, baked goods, margarine</i>)
<input type="checkbox"/>	Do you drink tea? How many per day? _____	<input type="checkbox"/>	Do you cook with polyunsaturated vegetable oils?
<input type="checkbox"/>	Do you drink fizzy drinks? How many per day? _____	<input type="checkbox"/>	Do you eat a very low fat diet?
<input type="checkbox"/>	Do you drink alcohol? How many glasses per week?		
	Wine _____ Beer _____ Spirits _____		

Please detail one typical WEEKDAY and one typical SATURDAY/SUNDAY food consumption:

BREAKFAST	BREAKFAST
LUNCH	LUNCH
EVENING MEAL	EVENING MEAL
SNACKS	SNACKS
DRINKS	DRINKS

WAIVER

I understand that a Nutritional Therapist is not able to diagnose or treat medical conditions. Nutritional advice is not intended to replace the advice of medical doctors. I understand that good nutrition helps build the body's natural strength and resistance. I also understand that no claim is made as to the certain efficacy of any nutritional protocols. Nutritional therapy is not a substitute for professional medical treatment.

Signed

Date