PRIVATE AND CONFIDENTIAL

I. O .N.

Nutrition Programme Questionnaire

This questionnaire is designed to provide your nutritionist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First Name: _____ **Last Name:** _____

Address: _____

_____

_____ **Post Code:** _____

Telephone Number: (Work) _____ (Home) _____

Occupation: _____ **Age:** _____

What is: **Your Weight** *(without clothes)*: _____ stones _____ lbs

Your Height *(without shoes)*: _____ feet _____ inches

Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems eg: Headaches 5 years. *(Continue on a separate sheet if you need more space.)*

Health problem	**Duration**
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

What medications *(drugs)* **do you take for these?** *State daily dosage.*_____

Under what circumstances do these problems improve?_____

Under what circumstances do they get worse?_____

What other illnesses have you had in the past ten years?_____

What operations have you had?_____

What is your normal blood pressure? *(don't worry if you don't know)*_____

What is your resting pulse rate per minute?_____
(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

Heredity Profile

Do you have any children? If so, state age and sex.

_____

How many brothers and sisters do you have? State age and sex.

_____

_____

Are there any particular illnesses that they suffer from?

_____

What illness is/was your father prone to?

_____

What illness is/was your mother prone to?

_____

SYMPTOM ANALYSIS

Each question in this section starts with a list of symptoms associated with nutritional deficiency. Underline the conditions you often suffer from. Some symptoms are repeated. Please underline them in all cases.

Mouth ulcers
Poor night vision
Acne
Frequent colds or infections
Dry flaky skin
Dandruff
Thrush or cystitis
Diarrhoea

Rheumatism or arthritis
Back ache
Tooth decay
Hair loss
Excessive sweating
Muscle cramps, or spasms
Joint pain or stiffness
Lack of energy

Lack of sex drive
Exhaustion after light exercise
Easy brusing
Slow would healking
Varicose veins
Loss of muscle tone
Infertility

Frequent colds
Lack of energy
Frequent infections
Bleeding or tender gums
Easy bruising
Nose bleeds
Slow wound healing
Red pimples on skin

Tender muscles
Eye pains
Irritability
Poor concentration
'Prickly' legs
Poor memory
Stomach pains
Constipation
Tingling hands
Rapid heart beat

Burning or gritty eyes
Sensitivity to bright lights
Sore tongue
Cataracts
Dull or oily hair
Eczema or dermatitis
Split nails
Cracked lips

Lack of energy
Diarrhoea
Insomnia
Headaches or migraines

Poor memory
Anxiety or tension
Depression
Irritability
Bleeding or tender gums
Acne

Muscle tremors or cramps
Apathy
Poor concentration
Burning feet or tender heels
Nausea or vomiting
Lack of energy
Exhaustion after light exercise
Anxiety or tension
Teeth grinding

Infrequent dream recall
Water retention
Tingling hands
Depression or nervousness
Irritability
Muscle tremors or cramps
Lack of energy
Flaky skin

Poor hair condition
Eczema or dermatitis
Mouth over-sensitive to hot or cold
Irritability
Anxiety or tension
Lack of energy
Constipation
Tender or sore muscles
Pale skin

Eczema
Cracked lips
Prematurely greying hair
Anxiety or tension
Poor memory
Lack of energy
Poor appetite
Stomach pains
Depression

Dry skin
Poor hair condition
Prematurely greying hair
Tender or sore muscles
Poor appetite or nausea
Eczema or dermatitis

Dry, rough skin
Dry eyes
Frequent infections
Poor memory
Loss of hair or dandruff
Excessive thirst

Poor wound healing
PMS or breast pain
Infertility

Muscle cramps or tremors
Insomnia or nervousness
Joint pain or arthritis
Tooth decay
High blood pressure

Muscle tremors or spasms
Muscle weakness
Insomnia or nervousness
High blood pressure
Irregular heart beat
Constipation
Fits or convulsions
Hyperactivity
Depression

Pale skin
Sore tongue
Fatigue or listlessness
Loss of appetite or nausea
Heavy periods or blood loss

Poor sense of taste or smell
White marks on more than two finger nails
Frequent infections
Stretch marks
Acne or greasy skin
Low fertility
Pale skin
Tendency to depression
Poor appetite

Muscle twitches
Childhood 'growing pains'
Dizziness or poor sense of balance
Fits or convulsions
Sore knees

Family history of cancer
Signs of premature ageing
Cataracts
High blood pressure
Frequent infections

Excessive or cold sweats
Dizziness or irritability after 6 hours without food
Need for frequent meals
Cold hands
Need for excessive sleep or drowsiness during the day
Excessive thirst
'Addicted' to sweet foods

LIFESTYLE ANALYSIS

Cardiovascular Profile

_____ Is your blood pressure above 140/90?
_____ Is your pulse after 15 minutes rest above 75?
_____ Are you more than 14lbs (7kg) over your ideal weight?
_____ Do you smoke more than 5 cigarettes a day?
_____ Do you do less than two hours exercise a week?
_____ Do you eat more than one spoon of sugar a day?
_____ Do you eat meat more than 5 times a week?
_____ Do you usually add salt to your food?
_____ Do you have more than 2 alcoholic drinks a day?
_____ Is there a history of heart disease in your family?

Exercise Profile

_____ Do you take exercise that noticeably raises your heart beat for 20 minutes for than 3 times a week?
_____ Does your job involve vigorous activity?
_____ Do you regularly play a sport? (football, squash, etc)
_____ Do you have any physically tiring hobbies? (gardening, etc)
_____ Do you consider yourself fit?

Pollution Risk Profile

_____ Do you live in a city or by a busy road?
_____ Do you spend more than 2 hours a week in traffic?
_____ Do you exercise (job, cycle, play sports) by busy roads?
_____ Do you smoke more than 5 cigarettes a day?
_____ Do you live or work in a smoky atmosphere?
_____ Do you buy foods exposed to exhaust fumes?
_____ Do you generally eat non-organic produce?
_____ Do you drink more than 1 unit or oz of alcohol a day? (1 glass of wine, 1 pint of beer, or 1 measure of spirits)
_____ Do you spend a lot of time in front of a TV or VDU?

Stress Profile

_____ Is your energy less now than it used to be?
_____ Do you feel guilty when relaxing?
_____ Do you have a persistent need for achievement?
_____ Are you unclear about your goals in life?
_____ Are you especially competitive?
_____ Do you work harder than most people?
_____ Do you easily become angry?
_____ Do you often do 2 or 3 tasks simultaneously?
_____ Do you get impatient if people or things hold you up?
_____ Do you have difficulty getting to sleep?

Glucose Tolerance Profile

_____ Do you need more than 8 hours sleep a night?
_____ Are you rarely wide awake within 20 minutes of rising?
_____ Do you need something to get you going in the morning, like a tea, coffee or cigarette?
_____ Do you have tea, coffee, sugar containing goods or drinks, or cigarettes, at regular intervals during the day?
_____ Do you get dizzy or irritable if you don't eat often?
_____ Do you avoid exercise due to tiredness?
_____ Do you sweat a lot or get excessively thirsty?
_____ Do you sometimes lose concentration?
_____ Is your energy less now than it used to be?

Digestion Profile

_____ Do you chew your food thoroughly?
_____ Do you sometimes suffer from bad breath?
_____ Are you prone to stomach upsets?
_____ Do you often get a burning sensation in your stomach?
_____ Do you find it difficult digesting fatty foods?
_____ Do you occasionally use indigestion tablets?
_____ Do you suffer from flatulence or bloating?
_____ Do you experience anal irritation?
_____ Do you have a bowel movement daily?
_____ Do your stools float?

Immune Profile

_____ Do you get more than three colds a year?
_____ Do you find it hard to shift an infection (cold or otherwise)?
_____ Are you prone to thrush or cystitis?
_____ Do you often take antibiotics more than twice a year?
_____ Is there a history of cancer in your family?
_____ Have you ever had any growths or lumps biopsied?
_____ Do you have an inflammatory disease such as eczema, asthma or arthritis?
_____ Do you suffer from hayfever?
_____ Do you suffer from allergy problems?
_____ Have you had a major personal loss in the last year?

Histamine Profile

Underline the following that apply to you:

Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious by nature, fat or 'well covered', can tolerate pain.

Sleep less than 7 hours, strong sex drive, little body hair, family history of allergies, fast metabolism, 'morning person', long toes and fingers, tends towards depression, don't put on weight, poor tolerance of pain.

Allergy Profile

Do you suffer from any of the following? Please underline.

Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.

Do you have any allergies? _____ If so what?
_____

State type of reaction. _____

Have they been tested? _____

What food or drinks would you find hard to give up? _____

_____

For women's health, please complete the appropriate woman's questionnaire.

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 in the question.

1. _____ Were you breast fed?
2. _____ Was a significant percentage of your diet as a child high in fatty foods and sugar?
3. _____ Do you go out of your way to avoid foods containing preservatives or additives?
4. _____ How many teaspoons of sugar do you add to food/drinks each day?
5. _____ Do you use salt in your cooking?
6. _____ Do you add salt to your food?
7. _____ How many coffees do you drink each day?
8. _____ How many cups of teas do you drink each day?
9. _____ How many times a week do you have meals containing fried food?
10. _____ How many packets of 'instant' or fast foods do you at each week?
11. _____ How many times a week do you eat chocolate or confectionery?
12. _____ What percentage of your diet is raw fruit and raw vegetables?
13. _____ Do you wash fruit and vegetables before eating?
14. _____ Do you normally eat white rice or flour?
15. _____ How many cans of food do you eat per week?
16. _____ How many slices of bread or rolls do you eat each week?
17. _____ How many pints of milk do you drink in a week?
18. _____ How many times a week do you at red meat? (beef, pork, lamb or game)
19. _____ How many times a week do you eat white meat? (poultry, fish)
20. _____ What is your usual alcoholic drink?
21. _____ How many glasses do you drink a week?
22. _____ How many times a week do you eat live yoghurt?
23. _____ Do you use a water filter or drink bottled water instead of tap water?
24. _____ Do you frequently eat under stressful conditions or on the move?
25. _____ Does your job involve eating out a lot?
26. _____ How would you describe your appetite?
    (a) poor (b) average (c) good

Please list below any supplements or medication you are currently taking: