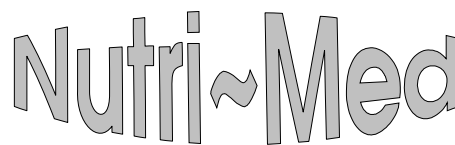


# PRIVATE AND CONFIDENTIAL Nutrition Programme Questionnaire



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.

## Your Contact Details

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Post code: \_\_\_\_\_  
Telephone number: (work) \_\_\_\_\_ (home) \_\_\_\_\_  
E-mail address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Age: \_\_\_\_\_  
What is: Your weight (without clothes): \_\_\_\_\_ stone \_\_\_\_\_ lbs  
Your height (without shoes): \_\_\_\_\_ feet \_\_\_\_\_ inches

## Your GP's Contact Details

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Post code: \_\_\_\_\_  
Telephone number: \_\_\_\_\_

## 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; e.g. 'Headaches, 5 years' (Continue on a separate sheet if you need more space).

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

Do you have any amalgam (metal) tooth fillings? \_\_\_\_\_

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.

Are there any particular illnesses that they suffer from?

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

What illness is/was your father prone to?

\_\_\_\_\_

What illness is/was your mother prone to?

\_\_\_\_\_

\_\_\_\_\_

Each question in this section starts with a list of symptoms associated with nutritional deficiency. Place a tick or cross beside the conditions you often suffer from. Some symptoms are repeated - please tick 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 bruising**
- Slow wound healing**
- 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**
- Constipation
- Tender or sore muscles
- Pale skin
  
- 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 nervous
- 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 above 75 after 15 minutes rest?
- 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 in a week?
- Do you eat more than one spoon of sugar per day?
- Do you eat meat more than five times a week?
- Do you usually add salt to your food?
- Do you have more than two alcoholic drinks per 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 more 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 two hours a week in traffic?
- Do you exercise (*jog, cycle, play sports*) by busy roads?
- Do you smoke more than five 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?
- Do you usually drink unfiltered tap water?

## 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 two or three 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 eight hours sleep a night?
- Are you rarely awake within twenty minutes of rising?
- Do you need something to get you going in the morning, like tea, coffee or a cigarette?
- Do you have tea, coffee or sugar-containing foods or drinks, or cigarettes, at regular intervals during the day?
- Do you often feel drowsy 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 hay fever?
- Do you suffer from allergy problems?
- Have you had a major personal loss in the last year?

## Histamine profile

Tick any of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Sleep over 8 hours     | <input type="checkbox"/> Sleep less than 7 hours     |
| <input type="checkbox"/> Little sex drive       | <input type="checkbox"/> Strong sex drive            |
| <input type="checkbox"/> Much body hair         | <input type="checkbox"/> Little body hair            |
| <input type="checkbox"/> Infrequent colds       | <input type="checkbox"/> Family history of allergies |
| <input type="checkbox"/> Sluggish metabolism    | <input type="checkbox"/> Fast metabolism             |
| <input type="checkbox"/> Slow to wake up        | <input type="checkbox"/> 'morning person'            |
| <input type="checkbox"/> Short toes and fingers | <input type="checkbox"/> Long toes and fingers       |
| <input type="checkbox"/> Suspicious by nature   | <input type="checkbox"/> Tends towards depression    |
| <input type="checkbox"/> Fat or 'well covered'  | <input type="checkbox"/> Don't put on weight         |
| <input type="checkbox"/> Can tolerate pain      | <input type="checkbox"/> Poor tolerance of pain      |

## Allergy profile

Do you suffer from any of the following? Tick any that apply.

- 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? \_\_\_\_\_

## Additional questions for Women Only

- Are you pregnant? If so, how many weeks? \_\_\_\_\_
- Are you trying to become pregnant?
- Have you ever had a miscarriage?
- Do you have an IUD fitted, or use the birth control pill?  
State which: \_\_\_\_\_
- Are your periods regular?
- Are you post-menopausal?
- Do you suffer from any pre-menstrual: (please tick)
- bloatedness  tiredness
- irritability  depression
- breast tenderness  headaches

## 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.

- |  |   |
|--|---|
| <p>1. _____ Were you breast fed?</p> <p>2. _____ Was a significant amount of your diet as a child high in fatty foods and sugar?</p> <p>3. _____ Do you go out of your way to avoid foods containing preservatives or additives?</p> <p>4. _____ Do you avoid foods which contain sugar?</p> <p>5. _____ How many teaspoons of sugar do you add to food/drinks each day?</p> <p>6. _____ Do you use salt in your cooking?</p> <p>7. _____ Do you add salt to your food?</p> <p>8. _____ How many coffees do you drink each day?</p> <p>9. _____ How many cups of tea do you drink each day?</p> <p>10. _____ How many times a week do you have meals containing fried food?</p> <p>11. _____ How many packets of 'instant' or fast foods do you eat each week?</p> <p>12. _____ How many times a week do you eat chocolate or confectionery?</p> | <p>13. _____ What percentage of your diet is raw fruit and raw vegetables</p> <p>14. _____ Do you wash fruit and vegetables before eating them?</p> <p>15. _____ Do you normally eat white rice or flour?</p> <p>16. _____ How many cans of food do you eat per week?</p> <p>17. _____ How many slices of bread or rolls do you eat each week?</p> <p>18. _____ How many pints of milk do you drink in a week?</p> <p>19. _____ How many times a week do you eat red meat? (<i>beef, pork, lamb or game</i>)</p> <p>20. _____ How many times a week do you eat white meat? (<i>poultry, fish</i>)</p> <p>21. _____ What is your usual alcoholic drink?</p> <p>22. _____ How many glasses do you drink a week?</p> <p>23. _____ How many times a week do you eat live yoghurt?</p> <p>24. _____ Do you use a water filter or drink bottled water instead of tap water?</p> <p>25. _____ Do you frequently eat under stressful conditions or on the move?</p> <p>26. _____ Does your job involve eating out a lot?</p> <p>27. _____ How would you describe your appetite?<br/> a) poor                      b) average                      c) good</p> |
|--|---|

**Write down all the foods and drinks you consume over the next two days, starting today.  
Please add as much information as possible including quantities eaten, brand names, and whether the food is fresh or packaged, refined or natural.**

Day 1	Day 2
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks/drinks	Snacks/drinks

Are these two days representative of your usual eating habits? If not, what is a more usual day?	What nutritional supplements do you take daily on a regular basis?
Breakfast	
Lunch	
Dinner	
Snacks/drinks	

**When completed, please return this form to:**  
Anne Pemberton  
Nutri-Med  
6 Laurel Hill Way, Colton Village  
Leeds LS15 9EW  
<http://www.nutrimed.co.uk/>