

NUTRITION PROGRAMME QUESTIONNAIRE

PRIVATE AND CONFIDENTIAL

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:

E-mail:

Telephone number: (Work)

(Home)

Occupation:

Date of birth:

Your weight (without clothes):

Your height (without shoes):

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: Headaces 5 years (Continue on a separate sheet if you need more space)

Health Problem

Duration

1

2

3

4

5

6

What medication (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 your siblings 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?

SYMPTOM ANALYSIS

This section lists symptoms associated with particular nutritional deficiencies. Tick the conditions you suffer from. You can select conditions by pointing and clicking with your mouse at the grey tick boxes. Some symptoms are repeated. Please tick them in all cases.

Mouth ulcers	<input type="checkbox"/>	Muscle tremors or cramps	<input type="checkbox"/>	Muscle tremors or spasms	<input type="checkbox"/>
Poor night vision	<input type="checkbox"/>	Apathy	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>
Acne	<input type="checkbox"/>	Poor concentration	<input type="checkbox"/>	Insomnia or nervousness	<input type="checkbox"/>
Frequent colds or infections	<input type="checkbox"/>	Burning feet or tender heels	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Dry flaky skin	<input type="checkbox"/>	Nausea or vomiting	<input type="checkbox"/>	Irregular heart beat	<input type="checkbox"/>
Dandruff	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Constipation	<input type="checkbox"/>
Thrush or cystitis	<input type="checkbox"/>	Exhaustion after light exercise	<input type="checkbox"/>	Fits or convulsions	<input type="checkbox"/>
Diarrhoea	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>	Hyperactivity	<input type="checkbox"/>
		Teeth grinding	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Rheumatism or arthritis	<input type="checkbox"/>	Infrequent dream recall	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>
Back ache	<input type="checkbox"/>	Water retention	<input type="checkbox"/>	Sore tongue	<input type="checkbox"/>
Tooth decay	<input type="checkbox"/>	Tingling hands	<input type="checkbox"/>	Fatigue or listlessness	<input type="checkbox"/>
Hair loss	<input type="checkbox"/>	Depression or nervousness	<input type="checkbox"/>	Loss of appetite or nausea	<input type="checkbox"/>
Excessive sweating	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Heavy periods or blood loss	<input type="checkbox"/>
Muscle cramps, or spasms	<input type="checkbox"/>	Muscle tremors or cramps	<input type="checkbox"/>		
Joint pain or stiffness	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Poor sense of taste or smell	<input type="checkbox"/>
Lack of energy	<input type="checkbox"/>	Flaky skin	<input type="checkbox"/>	White marks on more than two finger nails	<input type="checkbox"/>
Lack of sex drive	<input type="checkbox"/>	Poor hair condition	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>
Exhaustion after light exercise	<input type="checkbox"/>	Eczema or dermatitis	<input type="checkbox"/>	Stretch marks	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	Mouth over sensitive to hot or cold	<input type="checkbox"/>	Acne or greasy skin	<input type="checkbox"/>
Slow wound healing	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Low fertility	<input type="checkbox"/>
Varicose veins	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>
Loss of muscle tone	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Tendency to depression	<input type="checkbox"/>
Infertility	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>
		Tender or sore muscles	<input type="checkbox"/>	Muscle twitches	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	Pale skin	<input type="checkbox"/>	Childhood 'growing pains'	<input type="checkbox"/>
Lack of energy	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	Dizziness or poor sense of balance	<input type="checkbox"/>
Frequent infections	<input type="checkbox"/>	Cracked lips	<input type="checkbox"/>	Fits or convulsions	<input type="checkbox"/>
Bleeding or tender gums	<input type="checkbox"/>	Prematurely greying hair	<input type="checkbox"/>	Sore knees	<input type="checkbox"/>
Easy bruising	<input type="checkbox"/>	Anxiety or tension	<input type="checkbox"/>		
Nose bleeds	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	Family history of cancer	<input type="checkbox"/>
Slow wound healing	<input type="checkbox"/>	Lack of energy	<input type="checkbox"/>	Signs or premature ageing	<input type="checkbox"/>
Red pimples on skin	<input type="checkbox"/>	Poor appetite	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>
		Stomach pains	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>
Tender muscles	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	Excessive or cold sweats	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	Poor hair condition	<input type="checkbox"/>	Dizziness or irritability after 6 hours without food	<input type="checkbox"/>
Poor concentration	<input type="checkbox"/>	Prematurely greying hair	<input type="checkbox"/>	Need for frequent meals	<input type="checkbox"/>
'Prickly' legs	<input type="checkbox"/>	Tender or sore muscles	<input type="checkbox"/>	Cold hands	<input type="checkbox"/>
Poor memory	<input type="checkbox"/>	Poor appetite or nausea	<input type="checkbox"/>	Need for excessive sleep or drowsiness during the day	<input type="checkbox"/>
Stomach pains	<input type="checkbox"/>	Eczema or dermatitis	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>
Stomach pains	<input type="checkbox"/>			'Addicted' to sweet foods	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Dry, rough skin	<input type="checkbox"/>		
Tingling hands	<input type="checkbox"/>	Dry eyes	<input type="checkbox"/>		
Rapid heart beat	<input type="checkbox"/>	Frequent infections	<input type="checkbox"/>		
		Poor memory	<input type="checkbox"/>		
Burning or gritty eyes	<input type="checkbox"/>	Loss of hair or dandruff	<input type="checkbox"/>		
Sensitivity to bright lights	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>		
Sore tongue	<input type="checkbox"/>	Poor wound healing	<input type="checkbox"/>		
Cataracts	<input type="checkbox"/>	PMS or breast pain	<input type="checkbox"/>		
Dull or oily hair	<input type="checkbox"/>	Infertility	<input type="checkbox"/>		
Eczema or dermatitis	<input type="checkbox"/>				
Split nails	<input type="checkbox"/>	Muscle cramps or tremors	<input type="checkbox"/>		
Cracked lips	<input type="checkbox"/>	Insomnia or nervousness	<input type="checkbox"/>		
		Joint pain or arthritis	<input type="checkbox"/>		
Lack of energy	<input type="checkbox"/>	Tooth decay	<input type="checkbox"/>		
Diarrhoea	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>		
Insomnia	<input type="checkbox"/>				
Headaches or migraines	<input type="checkbox"/>				
Poor memory	<input type="checkbox"/>				
Anxiety or tension	<input type="checkbox"/>				
Depression	<input type="checkbox"/>				
Irritability	<input type="checkbox"/>				
Bleeding or tender gums	<input type="checkbox"/>				
Acne	<input type="checkbox"/>				

LIFESTYLE ANALYSIS

Please answer 'Yes' or 'No' to the questions below.

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 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 2 hours a week in traffic?
- _____ Do you exercise (jog, 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 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 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 tea, coffee or a cigarette?
- _____ Do you have tea, coffee, 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?

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 the following the apply to you:

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

Allergy Profile

Do you suffer from any of the following? Please tick

- | | |
|---|---|
| <input type="checkbox"/> Nasal problems | <input type="checkbox"/> Migraine |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Frequent bloatedness |
| <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Facial puffiness |
| <input type="checkbox"/> Asthma | |

Do you have any allergies? _____

If so, what? _____

State type of reaction? _____

Have you 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 symptoms? (tick which ones)

<input type="checkbox"/> Bloating	<input type="checkbox"/> Tiredness
<input type="checkbox"/> Irritability	<input type="checkbox"/> Depression
<input type="checkbox"/> Breast tenderness	<input type="checkbox"/> Headaches

DIET ANALYSIS

Please answer 'Yes' or 'No' or indicate number of times you eat the food referred to in the question.

- | | |
|--|--|
| <p>1. _____ Were you breast fed?</p> <p>2. _____ Was a significant percentage 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 deep-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 confectionary?</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?</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?
 <input type="checkbox"/> Poor <input type="checkbox"/> Average <input type="checkbox"/> Good</p> |
|--|--|

Write down all the foods and drinks consumed 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

Breakfast

Lunch

Dinner

Snacks/Drinks

Day 3

Breakfast

Lunch

Dinner

Snacks/Drinks

Day 2

Breakfast

Lunch

Dinner

Snacks/Drinks

What nutritional supplements do you take daily on a regular basis?

I hereby confirm that this information is correct to the best of my knowledge and that I am not withholding any important information.

Signed: _____

Date: _____

Please return this form to Halina either by scanning it and e-mailing it to her (halina@chelseanaturalhealth.co.uk) or by post to the clinic , Chelsea Natural Health, 208 Fulham Rd, London, SW10 9PJ