# nutrikind nutrition.

**HEALTH QUESTIONNAIRE- PLEASE FILL IN ALL SECTIONS**

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| PATIENT INFORMATION | | | | | | | | | | | | | | | | |
| **NAME** | | | | | |  | | | |  | **❑ MR.**  **❑ MRS.** | | **❑ MISS**  **❑ MS.** | | **MARITAL STATUS :** | |
|  | | | | | | | | | | |  | |
| **AGE:** | **D.O.B:** | | | | | | | | | | **HOME PHONE NO:**  **MOBILE NO:** | | | | | |
| **WEIGHT & HEIGHT:** |  | | | | | | | | | |  | | | | | |
| **ADDRESS :** | | **SECOND LINE ADDRESS :** | | | | | | | | | | **CITY:** | | | | **POSTCODE :** |
|  | |  | | | | | | | | | |  | | | |  |
| **OCCUPATION :** | | **EMAIL ADDRESS :** | | | | | | | | | | | | **DEPENDENTS :** | | |
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| main reasons for visiting the clinic (goals) | | | | | | | | | | | | | | | | |
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| **IS THERE ANYTHING SUCH AS SEASONS, ENVIRONMENTS, PLACES THAT CAUSE SYMPTOMS TO WORSEN? :** | | | |  |  | | |  | | | | | |  | | |
| **IS YOUR DIET BASED ON ANY RELIGIOUS REQUIREMENTS/ SPECIAL DIETARY REQUIREMENTS, OR ARE THEIR ANY FOODS YOU DO NOT LIKE? :**  **DO YOU HAVE ANY ALLERGIES?** | | |  | | | |  | |  | | | | | | | |

**MEDICAL HISTORY (PLEASE INCLUDE ALL TESTS, MEDICAL INTERVENTIONS, DIAGNOSES, IF YOU ARE UNDER THE HOSPITAL FOR INVESTIGATIONS ETC):**

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| **HEALTH HISTORY, ILLNESSES, OPERATIONS** | **AGE OF ONSET** | **DURATION** | **MEDICATION** |
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| **PLEASE SPECIFY ANY REGULAR MEDICATION YOU ARE TAKING:** |

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| **ARE YOU UNDERGOING ANY MEDICAL TREATMENT?** | **LAST COURSE OF ANTIBIOTICS.** |

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| **NUTRITIONAL SUPPLEMENTS YOU ARE TAKING? (PLEASE LIST DOSES & BRANDS OF EACH)** |

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| **MEDICAL HISTORY IN FAMILY? (FATHER, MOTHER, SIBLINGS) :** |

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| **LIFESTYLE: SEDENTARY……… MODERATELY ACTIVE…….... ACTIVE……… VERY ACTIVE……….**  **(PLEASE STATE HOW MUCH/OFTEN EXERCISE & WHAT TYPE?)** |

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| **AVERAGE WEEKLY INTAKE OF ALCOHOL? (UNITS/GLASSES)**  **WEEKDAY:**  **WEEKEND:** | **DO YOU SMOKE?**  **HOW MANY/ DAY?**  **IF DID, WHEN GAVE UP?** |

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| **HOW MOTIVATED ARE YOU TO CHANGE?** |

**HEALTH SCREEN: \*Please only fill the mild section in if you have these symptoms & they are mild.**

**1= MILD 2=MODERATE 3=SEVERE**

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| **1** | **2** | **3** | **SECTION 1** |
|  |  |  | **POOR MEMORY** |
|  |  |  | **CONFUSION** |
|  |  |  | **POOR CONCENTRATION** |
|  |  |  | **POOR COORDINATION** |
|  |  |  | **DIFFICULTY MAKING DECISIONS** |
|  |  |  | **ANY OF ABOVE MADE WORSE BY SKIPPING MEAL** |

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| **1** | **2** | **3** | **SECTION 2** |
|  |  |  | **HEADACHE** |
|  |  |  | **DIZZINESS/FAINTNESS** |
|  |  |  | **INSOMNIA** |

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| **1** | **2** | **3** | **SECTION 3** |
|  |  |  | **WATERY/ ITCHY EYES** |
|  |  |  | **SWOLLEN/REDDENED/STICKY EYELIDS** |
|  |  |  | **SENSITIVE TO BRIGHT LIGHT** |
|  |  |  | **BLURRED/TUNNEL VISION** |

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| **1** | **2** | **3** | **SECTION 4** |
|  |  |  | **ITCHY EARS** |
|  |  |  | **EARACHES/INFECTIONS** |
|  |  |  | **DISCHARGE FROM EAR** |
|  |  |  | **RINGING IN EARS** |

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| **1** | **2** | **3** | **SECTION 5** |
|  |  |  | **STUFFY NOSE/SINUS PROBLEMS** |
|  |  |  | **HAYFEVER** |
|  |  |  | **EXCESSIVE MUCUS FORMATION** |
|  |  |  | **SENSITIVE TO STRONG SMELLS** |

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| **1** | **2** | **3** | **SECTION 6** |
|  |  |  | **CHRONIC COUGH** |
|  |  |  | **GAGGING** |
|  |  |  | **FREQUENT NEED TO CLEAR THROAT** |
|  |  |  | **SORE THROAT/HOARSENESS** |
|  |  |  | **SORE TONGUE** |
|  |  |  | **PRONE TO COLD SORES** |

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| **1** | **2** | **3** | **SECTION 7** |
|  |  |  | **IRREGULAR/SKIPPED HEARTBEAT** |
|  |  |  | **RAPID/POUNDING HEARTBEAT** |
|  |  |  | **CHEST PAIN** |

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| **1** | **2** | **3** | **SECTION 8** |
|  |  |  | **CHEST CONGESTION/WHEEZING** |
|  |  |  | **ASTHMA** |
|  |  |  | **SHORTNESS OF BREATH** |
|  |  |  | **DIFICULTY BREATHING** |

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| **1** | **2** | **3** | **SECTION 9** |
|  |  |  | **NAUSEA/VOMITING** |
|  |  |  | **DIARRHOEA** |
|  |  |  | **CONSTIPATION** |
|  |  |  | **BLOOD OR MUCUS IN STOOLS** |
|  |  |  | **BLOATED FEELING** |
|  |  |  | **STOOLS HAVE GREASY APPEARANCE** |
|  |  |  | **BELCHING/PASSING WIND** |
|  |  |  | **HEARTBURN** |

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| **1** | **2** | **3** | **SECTION 10** |
|  |  |  | **ACNE** |
|  |  |  | **HIVES/RASH/DRY SKIN** |
|  |  |  | **HAIR LOSS** |
|  |  |  | **FLUSHING OR HOT FLUSHES** |
|  |  |  | **EXCESSIVE SWEATING** |
|  |  |  | **SOFT, FRAYING, BRITTLE NAILS** |

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| **1** | **2** | **3** | **SECTION 11** |
|  |  |  | **WATER RETENTION** |
|  |  |  | **BINGE EATING/DRINKING** |
|  |  |  | **CRAVINGS FOR CERTAIN FOODS** |
|  |  |  | **LACK OF APPETITE** |
|  |  |  | **COMPULSIVE EATING** |

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| **1** | **2** | **3** | **SECTION 12** |
|  |  |  | **FREQUENT ILLNESS** |
|  |  |  | **FREQUENT/URGENT URINATION** |
|  |  |  | **GENERAL ITCH/DISCHARGE** |
|  |  |  | **EXCESSIVE THIRST** |
|  |  |  | **LOSS OF TASTE/SMELL** |

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| **1** | **2** | **3** | **SECTION 13 (WOMEN)** |
|  |  |  | **MENSTRUAL PAIN** |
|  |  |  | **TENDER/PAINFUL BREASTS** |
|  |  |  | **MOOD CHANGE BEFORE PERIOD** |

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| **1** | **2** | **3** | **SECTION 14 (MEN)** |
|  |  |  | **DIFFICULT URINATION** |
|  |  |  | **LOSS OF LIBIDO** |
|  |  |  | **MOOD CHANGES** |

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| **1** | **2** | **3** | **SECTION 15** |
|  |  |  | **MOOD SWINGS** |
|  |  |  | **ANXIETY, FEAR, NERVOUSNESS** |
|  |  |  | **ANGER, IRRITABILITY, AGGRESSIVENESS** |
|  |  |  | **DEPRESSION** |

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| **1** | **2** | **3** | **SECTION 16** |
|  |  |  | **FATIGUE, SLUGGISHNESS** |
|  |  |  | **APATHY, LETHARGY** |
|  |  |  | **HYPERACTIVITY** |
|  |  |  | **RESTLESSNESS** |

**LIFESTYLE ANALYSIS**

***Please tick all of the symptoms or scenarios that apply to you even if some symptoms are repeated***

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| **CARDIOVASCULAR PROFILE**   1. Blood pressure above 140/90 2. Overweight 3. High cholesterol 4. Seldom exercise vigorously 5. Job involves vigorous activity 6. Consider yourself fit 7. Family history of heart disease 8. Smoker or exposed to smoke at home or work 9. Recreational drug user 10. Consume more than two alcoholic drinks a day 11. Consume more than one spoon of sugar a day 12. Consume meat more than five times a week 13. Add salt to your food | **DIGESTIVE PROFILE (u*pper gastrointestinal system)***   1. Belching or gas within 1 hour of a meal 2. Heartburn or Acid Reflux 3. Burning sensation in the stomach 4. Occasionally use indigestion tablets 5. Bloating shortly after eating 6. Flatulence 7. Often sleepy after meals 8. Stomach upset by taking vitamin supplements 9. Hurried eating habits 10. Chew your food thoroughly 11. Bad breath (Halitosis) 12. Undigested food in stools 13. Fingernails which chip, peel, or break easily |
| **IMMUNITY PROFILE**   1. Never get sick 2. More than three colds a year 3. Find it hard to shift an infection (cold or otherwise) 4. Frequent infections: Ear, sinus, lung, skin, bladder kidney 5. History of: Glandular Fever, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition 6. History of frequent antibiotic use 7. Itchy skin or dermatitis 8. Hay fever 9. Eczema 10. Asthma 11. Arthritis 12. Allergies 13. Excessive ear wax | **LIVER AND GALLBLADDER PROFILE**   1. History of drug or alcohol abuse/ frequent drinking 2. Stomach upset by greasy foods 3. History of hepatitis 4. Nausea 5. Long-term use of prescription medications 6. Light or clay-coloured stools 7. Sensitive to chemicals *(e.g. perfume, cleaning solvents, insecticides, car exhausts, etc)* 8. Gallbladder removed 9. Hurried eating habits/ don’t chew food thoroughly 10. Overeating 11. Easily intoxicated by alcohol 12. Chronic Fatigue or Fibromyalgia 13. Allergies 14. Frequent vaccinations for foreign travel |
| **ADRENAL PROFILE**   * 1. Insomnia   2. Crave salty foods   3. Slow starter in the morning   4. Muscles easily fatigued   5. Feel wired or jittery when drinking coffee   6. Chronic fatigue, or often feel drowsy   7. Clench or grind teeth   8. Calm on the outside, troubled inside   9. Afternoon headache   10. Dizzy when suddenly standing up   11. Allergies and/or hives | **SMALL INTESTINE** **PROFILE**   1. Are there foods you could not give up? *(Please state)*   **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**   1. Food allergies 2. Abdominal bloating 1-2 hours after eating 3. Asthma 4. Sinus infections, stuffy nose 5. Specific foods make you tired or bloated 6. Sometimes feel ‘spacey’ or unreal 7. Alternating constipation and diarrhoea 8. Airborne allergies *(e.g. hay feve*r) 9. Suffer from Hives |
| **BLOOD SUGAR PROFILE**   1. Awaken a few hours after falling asleep, hard to get back to sleep 2. Fatigue that is relieved by eating 3. Crave sweets 4. Headaches if meals are skipped or delayed 5. Shaky if meals are delayed 6. Irritable before meals 7. Depression or mood swings 8. Binge or uncontrolled eating 9. Excessive appetite 10. Eat desserts or sugary snacks 11. Crave coffee or sugar in the afternoon 12. Frequent thirst 13. Frequent urination 14. Family members with diabetes | **LARGE INTESTINE PFOFILE**   * 1. Anal itching   2. Less than 1 bowel movement per day   3. Stools hard or difficult to pass   4. Stools loose or not well formed   5. Cramps in lower abdominal region   6. Excessive or foul lower bowel gas   7. Blood in stools   8. Mucus in stools   9. History of parasite infection   10. Feel worse in musty or mouldy atmosphere   11. Irritable bowel syndrome   12. Fungus or yeast infections *(e.g. nail fungus, athletes foot, thrus*h, candida) |

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| **THYROID PROFILE**   1. Allergic to Iodine 2. Mentally sluggish, reduced initiative 3. Easily fatigued, sleepy during the day 4. Sensitive to cold – poor circulation 5. Constipation – chronic 6. Loss of lateral third of eyebrow 7. Seasonal sadness 8. Difficulty gaining weight, even with large appetite 9. Nervous, emotional, can’t work under pressure 10. Difficulty losing weight 11. Fast pulse at rest 12. Intolerance to high temperatures | **WOMEN ONLY QUESTIONS**   1. Are you pregnant? How many weeks\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2. Are you trying to conceive? 3. Have you ever been pregnant? 4. Have you ever had a miscarriage? 5. Do you have an IUD fitted? 6. Do you use the contraceptive pill? 7. Is your menstrual cycle regular? 8. How long is your cycle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 9. Occasional skipped periods 10. Pre – menstrual bloating tiredness, irritability, depression, mood swings, breast tenderness, headaches?***(please underline)*** 11. Period pain 12. Excess facial or body hair 13. Minimal blood flow during periods 14. Excessive menstrual flow 15. Blood clots in menstrual flow 16. Hot flushes 17. Vaginal dryness 18. Are you post menopausal? 19. Vaginal discharge and itchiness 20. Frequent thrush |
| **MEN ONLY QUESTIONS**   1. Prostate problems 2. Waking regularly to urinate at night 3. Difficult to start & stop urine stream 4. Decreased sexual function 5. Pain or burning sensation when urinating |  |

**ADDITIONAL QUESTIONS:**

1. Do you have amalgam (metal) fillings?

2. Have you travelled extensively abroad?

3. Did you have vaccinations as a child?

4. Do you work with chemicals?

5. Do you use natural or manmade products?

6. Do you take a lot of over the counter medications?

**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***

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

**FOOD DIARY- PLEASE FILL IN A FULL THREE DAYS FOR ANALYSIS & ONLY RECORD TYPICAL DAYS:**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **DATE** | **FOOD AND DRINK CONSUMED** | **ANY SYMPTOMS AFTER** |
| **TIME:** | **QUANTITY:** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **DATE** | **FOOD AND DRINK CONSUMED** | **SYMPTOMS** |
| **TIME** | **QUANTITY** |  |  |

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|  | **DATE** | **FOOD AND DRINK CONSUMED** | **SYMPTOMS** |
| **TIME** | **QUANTITY** |  |  |

**ADDITIONAL COMMENTS:**

**THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.**

**TERMS OF ENGAGEMENT**

**BETWEEN THE BANT NUTRITIONAL THERAPIST AND THE CLIENT**

**Introduction**

* Good nutrition helps build the body’s natural strength and resistance however, no claim is made as to the efficacy of any nutritional protocols.
* The degree of benefit obtainable from Nutritional Therapy may vary between clients with similar health problems and following a similar Nutritional Therapy programme.

**The Nutritional Therapist**

* Nutritional advice will be tailored to support diagnosed conditions and/or health concerns identified and agreed between both parties.
* Nutritional therapists are not permitted to diagnose, or claim to treat, medical conditions, Nutritional advice is not a substitute for professional medical advice and/or treatment.
* Standards of professional practice in Nutritional Therapy are governed by the BANT Code of Ethics and Practice.

**The Client**

* You are responsible for contacting your GP about any health concerns.
* If you are not being treated by your GP, you should still let him know that you are receiving nutritional therapy.
* If you are receiving treatment from your GP, or any other medical provider, you should tell him about any nutritional strategy provided by a nutritional therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
* It is important that you tell your nutritional therapist about any medical diagnosis, medication, herbal medicine, or food supplements, you are taking as this may affect the nutritional programme.
* If you are unclear about the agreed nutritional therapy programme / food supplement doses / time period, you should contact your nutritional therapist promptly for clarification.
* You must contact your nutritional therapist should you wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions.
* You are advised to report any concerns about Nutritional Therapy promptly to your nutritional therapist for discussion and action.

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We understand the above and agree that our professional relationship will be based on the content of this document.

Signed by client: ………………………………………….……… Date………..……….

Signed by nutritional therapist: ………………………………… Date…………………

*{A signed copy of the this document to be retained by both the client and the nutritional therapist}*

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