# nutrikind nutrition.

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

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|  |
| PATIENT INFORMATION |
| **NAME:** |  |  | **❑ MR.****❑ MRS.** | **❑ MISS****❑ MS.** | **MARITAL STATUS:** |
|  |  |
| **AGE:****WEIGHT & HEIGHT:** | **D.O.B:****TIME OF BIRTH:****PLACE OF BIRTH:** | **HOME PHONE NO:** **MOBILE NO:** |
|  |  |  |
| **ADDRESS:** | **SECOND LINE ADDRESS:** | **CITY:** | **POSTCODE:** |
|  |  |  |  |
| **OCCUPATION:** | **EMAIL ADDRESS:** | **DEPENDENTS:** |
|  |  |  |
|  |
| main reasons for visiting the clinic (goals) |
|  |
| **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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|  |  |
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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?

**PLEASE INCLUDE ANY TRAUMATIC EVENTS IN YOUR LIFE HERE (IF YOU WOULD PREFER NOT TO THEN THAT IS FINE):**

**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 ulcersPoor night visionAcneFrequent colds or infectionsDry flaky skinDandruffThrush or cystitisDiarrhoea | Lack of energyDiarrhoeaInsomniaHeadaches or migrainesPoor memoryAnxiety or tensionDepressionIrritabilityBleeding or tender gumsAcne | Dry, rough skinDry eyesFrequent infectionsPoor memoryLoss of hair or dandruffExcessive thirstPoor wound healingPMS or breast painInfertility  |
| Rheumatism or arthritisBack acheTooth decayHair lossExcessive sweatingMuscle cramps or spasmsJoint pain or stiffnessLack of energy | Muscle tremors or crampsApathyPoor concentrationBurning feet or tender heelsNausea or vomitingLack of energyExhaustion after light exerciseAnxiety or tensionTeeth grinding  | Muscle cramps or tremorsInsomnia or nervousnessJoint pain or arthritisTooth decayHigh blood pressure  |
| Lack of sex driveExhaustion after light exerciseEasy bruisingSlow wound healingVaricose veinsLoss of muscle toneInfertility | Muscle tremors or spasmsMuscle weaknessInsomnia or nervousnessHigh blood pressureIrregular heart beatConstipationFits or convulsionsHyperactivityDepression |
| Frequent colds Lack of energyFrequent infectionsBleeding or tender gumsEasy bruisingNose bleedsSlow wound healingRed pimples on skin | Infrequent dream recallWater retentionTingling handsDepression or nervousnessIrritabilityMuscle tremors or crampsLack of energyFlaky skin | Pale skinSore tongueFatigue or listlessnessLoss of appetite or nauseaHeavy periods or blood loss  |
| Tender musclesEye painsIrritabilityPoor concentration‘prickly’ legsPoor memoryStomach painsConstipationTingling handsRapid heart beat | Poor hair conditionEczema or dermatitisMouth over sensitive to hot or coldIrritabilityAnxiety or tensionLack of energyConstipationTender or sore musclesPale skin | Poor sense of taste or smellWhite marks on more than two fingernailsFrequent infectionsStretch marksAcne or greasy skinLow fertilityPale skinTendency to depressionPoor appetite |
| Burning or gritty eyesSensitivity to bright lightsSore tongueCataractsDull or oily hairEczema or dermatitisSplit nails Cracked lips | EczemaCracked lipsPrematurely greying hairAnxiety or tensionPoor memory Lack of energyPoor appetite Stomach painsDepression | Muscle twitchesChildhood ‘growing pains’Dizziness or poor sense of balanceFits or convulsionsSore knees |
| Family history of cancerSigns of premature ageingCataractsHigh blood pressureFrequent infections |
| Dry skinPoor hair conditionPrematurely greying hairTender or sore musclesPoor appetite or nausea Eczema / dermatitis | Excessive or cold sweatsDizziness or irritability after 6 hours without foodNeed for frequent meals Cold handsNeeds for excessive sleep or drowsiness during the dayExcessive 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** |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
|  | **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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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