NUTRIKIND NUTRITION.

HEALTH QUESTIONNAIRE- PLEASE FILL IN ALL SECTIONS

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):

HEALTH HISTORY, ILLNESSES, OPERATIONS	AGE OF ONSET	DURATION	MEDICATION

PLEASE SPECIFY ANY REGULAR MEDICATION YOU ARE TAKING:

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

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

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

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

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

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**

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

1	2	3	SECTION 2
			HEADACHE
			DIZZINESS/FAINTNESS
			INSOMNIA

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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)*
   _____
2. Food allergies
3. Abdominal bloating 1-2 hours after eating
4. Asthma
5. Sinus infections, stuffy nose
6. Specific foods make you tired or bloated
7. Sometimes feel 'spacey' or unreal
8. Alternating constipation and diarrhoea
9. Airborne allergies *(e.g. hay fever)*
10. 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)

THYROID PROFILE

2. Allergic to Iodine
3. Mentally sluggish, reduced initiative
4. Easily fatigued, sleepy during the day
5. Sensitive to cold – poor circulation
6. Constipation – chronic
7. Loss of lateral third of eyebrow
8. Seasonal sadness
9. Difficulty gaining weight, even with large appetite
10. Nervous, emotional, can't work under pressure
11. Difficulty losing weight
12. Fast pulse at rest
13. 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. <u>Underline the conditions you often suffer from.</u> <u>Some symptoms are repeated</u>. <u>Please underline them in all cases</u>

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**		

	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}