Polly Douglas
Nutritional Therapist

Please complete this document and if possible return it to me before your first consultation. This questionnaire is designed to provide 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.
All details on this questionnaire will be kept private and confidential.

Client Details

Title:..... Date of Birth:..... Age:.....

First Name:.....Last Name:.....

Address:.....

.....

Post Code:.....Email Address.....

Telephone No: (Work).....(Home).....

Occupation:.....

Weight:.....Stone .....lbs or.....Kg Height:.....Feet .....Inches or .....cm

Has your weight changed recently? Yes/No Details.....

Medical Doctors Name & Address:.....

Do you give permission for your medical doctor to be contacted? Yes..... No.....

Is your doctor aware of your intention to see a nutritional consultant? Yes..... No.....

Have you seen a nutritional consultant or any other health professional previously regarding your current symptoms or health issues? Yes..... No.....

Details.....

Have you had any blood, urine, saliva or other laboratory tests? Yes..... No.....

If YES please state which tests, and if possible bring a copy of the results with you.....

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Health Information

Please state your main health issues or reasons for seeking nutritional support in order of importance to you:

Health Concern	Duration	Management (drugs etc) /dosage
1.....	.....	.....
2.....	.....	.....
3.....	.....	.....
4.....	.....	.....
5.....	.....	.....

Please list any medication (prescribed or bought over the counter) that you take (including dose):

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Please list any nutritional supplements that you take (include dose, manufacturer and duration of use):

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Allergies Please state any allergies and the reaction that occurs:

Drugs/Medication:.....

Other allergies: .....

Past Medical History

What operations / illnesses did you have as a child?	What operations/ illnesses have you had as an adult?
.....	.....
.....	.....
.....	.....
.....	.....

Family History Please state any health problems experienced by your parents, siblings and children

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Exercise Profile

- Do you take exercise that raises your heartbeat for 20 minutes more than 3 times a week? Yes/No
- Does your job include lots of walking, lifting, or any other vigorous activity? Yes/No
- Do you have any physically tiring hobbies e.g. gardening, carpentry? Yes/No
- Are you in serious training for an athletic event? Yes/No
- Do you consider yourself fit? Yes/No

Lifestyle Profile

- Are/were you a smoker? If yes, how much and for how long? Yes/No
- Who do you live with at home?.....
- What do you do to relax (interest/hobbies/spiritual practices)?.....
  .....
- Do you use any recreational drugs? Yes/No

Additional Questions for Women Only:

- Please underline any symptoms you usually experience in the 1-2 weeks before your period
  Bloating/fluid retention, tiredness, irritability, depression, breast tenderness, headaches, food/sugar cravings, stomach cramps, lower back aches, acne, excessive bleeding, prolonged bleeding?
- Are you pregnant or trying to become pregnant? Yes..... No.....
- Do you or have you ever taken the contraceptive pill or used an IUD? Yes..... No.....
- Have you ever received any fertility treatment? Yes..... No.....
- Are you peri/postmenopausal? Yes..... No.....
- Do you, or have you ever taken HRT? Yes..... No.....
- If you are post-menopausal, aged 45 or over, do you suffer from any of the following (please underline): *Hot flushes, mood swings, vaginal dryness, loss of memory, depression, loss of libido, osteoporosis*
- Have you been diagnosed /treated for ovarian, endometrial, breast or cervical cancer? Yes..... No.....

Additional Questions For Men Only:

Do you have or have you ever had any of the following?

Altered urine flow	Yes..... No.....	Benign prostatic hypertrophy	Yes..... No.....
Impotence	Yes..... No.....	Infertility	Yes..... No.....
Low sperm count/motility	Yes..... No.....	Prostate or Testicular cancer	Yes..... No.....

Please tick to left of question if 'yes' or provide the information requested.

Energy & Glucose Tolerance

_____Please rate your daily energy levels on a scale of 1-10 (1=poor/ 10=great)
_____Are you rarely wide awake and raring to go within 20 minutes of rising?
_____Do you need something to get you going in the morning, like a cup of tea, coffee or a cigarette?
_____Do you crave tea, coffee, sugary foods or drinks, alcohol or cigarettes?
_____Do you often feel drowsy or sleepy during the day, or after meals?
_____Do you get dizzy or irritable if you have not eaten for 6 hours?
_____Do you sweat a lot or get excessively thirsty?
_____Do you need to urinate frequently?
_____Do you sometimes lose concentration or your mind go completely blank?

Stress Profile

_____Do you feel guilty when relaxing?
_____Do you find aspects of your life unfulfilling or frustrating?
_____Do you work harder than most people?
_____Do you easily get angry, irritable or impatient?
_____Do you often do 2 or 3 tasks at the same time?
_____Have you been subject to a period of prolonged or extreme stress?
_____Do you have difficulty getting to sleep, sleep restlessly or wake up during the night?

Digestion Profile

_____Do you often get burping or a feeling of fullness after meals?
_____Do you frequently eat in a rush or under stress?
_____Do you suffer from heartburn or indigestion?
_____Do you regularly suffer from wind and/or bloating?
_____Do you get pains or cramps in your stomach or abdomen?
_____How often do you have a bowel movement?
_____Do you have alternating constipation and diarrhoea?
_____Do your stools float?
_____Do you feel nauseous in the morning, after eating or after fatty foods?
_____Have you ever had a peptic ulcer?

Cardiovascular Profile

_____Have you ever had or do you have high blood pressure?
_____Is there a family history of heart disease or diabetes in your family?
_____Are you more than 14ib/7kg over your ideal weight?
_____Do you feel the cold or experience cold hands and feet?
_____Do you experience chest pain or palpitations?

Immune Profile

_____Were you breast fed as a child?
_____Have you taken 2 or more short (1-2 week courses) of antibiotics?
_____Have you taken 1 or more long (2+ weeks) courses of antibiotics?
_____Is there any history of cancer in your family? Please give details

Please underline any of the following to which you are prone:

Nasal/sinus problems, hayfever, asthma, skin eruptions, headaches, migraine, eczema, dermatitis, irritable bowel syndrome, fluid retention, facial puffiness, thrush or fungal infections, cystitis, arthritis, frequent colds and infections (more than 3 a year), difficulty shifting infections, genital itching, athlete's foot, depression, sensitivity to odours and tobacco, inability to tolerate alcohol.

Toxin Exposure

_____Do you live in a city or by a busy road?
_____Do you spend more than 2 hours a week in heavy traffic?
_____Do you exercise by busy roads?
_____Do you smoke more than 5 cigarettes a day?
_____Do you generally eat non-organic produce?
_____Do you wash fruit and vegetables before eating them?
_____Do you spend considerable time in front of a computer or TV?
_____Do you have one or more mercury amalgam fillings?

Nutrient Status – *The following is a list of potential nutrient deficiency symptoms. Please underline the symptoms which apply to you. Where symptoms are repeated, please underline them all.*

Mouth Ulcers
Poor night vision
Acne
Frequent colds and infections
Dry flaky skin
Dandruff
Thrush or cystitis
Diarrhoea

Arthritis or osteoporosis
Backache
Tooth Decay
Hair loss
Muscle twitching 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 pain
Irritability
Poor concentration
Prickly legs
Poor memory
Stomach pains
Constipation
Tingling hands
Rapid heartbeat

Bloodshot, burning or gritty eyes
Sensitivity to bright lights
Sore tongue
Cataracts
Dull or oily hair
Eczema or dermatitis
Split nails
Cracked lips

Dermatitis or dry skin
Poor hair condition
Prematurely greying hair
Tender or sore muscles
Poor appetite or nausea

Lack of energy
Diarrhoea
Insomnia
Headaches or migraines
Poor memory
Anxiety or tension
Depression
Irritability
Bleeding or tender gums
Acne

Muscle tremors, cramps or spasms
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, cramps, spasms
Lack of energy

Poor hair condition
Eczema or dermatitis
Mouth oversensitive to hot or cold
Irritability
Anxiety or tension
Lack of energy
Constipation
Tender or sore muscles
Pale skin

Eczema or dermatitis
Cracked lips
Prematurely greying hair
Anxiety or tension
Poor memory
Lack of energy
Depression
Poor appetite
Stomach pains

Dry skin, eczema or dry eyes
Dry hair or dandruff
Inflammatory health problems e.g. arthritis
Excessive thirst or sweating
PMS or breast pain
Water retention
Frequent infections
Poor memory or learning difficulties
High blood pressure or high cholesterol

Muscle cramps, tremors or spasms
Insomnia or nervousness
Joint pain or arthritis
Tooth decay
High blood pressure

Muscle cramps, tremors or spasms
Muscle weakness
Insomnia, restlessness or hyperactivity
High blood pressure
Irregular or rapid heartbeat
Constipation
Fits or convulsions
Breast tenderness or water retention
Depression or confusion

Pale skin
Sore tongue
Fatigue or listlessness
Loss of appetite or nausea
Heavy periods or blood loss

Poor sense of smell or taste
White marks on more than two fingernails
Frequent infections
Stretch marks
Acne or greasy skin
Low fertility
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 aging
Cataracts
High blood pressure

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
Addicted to sweet foods

Dietary Analysis

Please tick to left of question if 'yes' or provide the information requested.

PROTEIN AND FATS

_____ How many portions of red meat (beef, pork, lamb or game) do you eat per week?

_____ How many portions of poultry and fish do you eat per week?

_____ How many portions of oily fish (mackerel, salmon, herring, tuna, sardines) do you eat each week?

_____ Of this, how many portions are tuna?

_____ How many meals per week do you eat which contain fried foods?

_____ Do you try to avoid foods that are high in fat?

_____ Do you use butter or margarine?

_____ What type of oil/fat do you use to cook with?

CARBOHYDRATES

_____ How many teaspoons of sugar or honey do you add to food and drinks per day?

_____ Do you normally choose wholegrains (ie brown pastas, breads, flours, rice) instead of white and/or refined grains?

_____ How many portions of fruit do you eat per day? (on average)

_____ How many portions of vegetables do you eat per day? (on average)

_____ How many slices of bread do you eat each week?

_____ How many times per week do you eat chocolate, cakes or sweets?

_____ Do you try to avoid foods containing sugar?

_____ Do you eat consume fruit, fruit juices or honey more than twice daily?

DRINKS

_____ What is your usual alcoholic drink/s?

_____ How many units (1 glass/measure) of alcohol do you drink each week?

_____ How many coffees do you drink per day?

_____ How many cups of tea do you drink per day?

_____ How many pints of milk do you drink each week?

_____ How much plain water do you drink per day? Is it bottled/filtered/tap?

DIET CHOICES

_____ Are you or have you ever been vegetarian or vegan? If yes, for how long?

_____ Do you usually add salt to food during cooking or before eating?

_____ How many ready-made or 'fast' food meals do you eat per week?

_____ What percentage of your diet is raw food?

_____ What percentage of your diet is home prepared food?

_____ Do you try to avoid additives, preservatives and colourings?

_____ Do you snack regularly during the day?

_____ What percentage of your diet is organic food?

_____ How many times a week do you eat out or eat a take-away meal?

_____ Would you say you have a good appetite?

_____ Do you often skip meals? If so, which:

Please list any foods you currently avoid or restrict:

What foods do you crave or would you find it hard to give up?

Food Diary

Please write down all the foods and drinks that you consume over the next 3 days (or the previous 3 days). Please provide as much information as possible including quantity eaten, brand names and whether food was fresh or packaged. Please include any alcoholic drinks taken.

DAY 1

Breakfast

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Lunch

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Dinner

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Snacks/Drinks

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DAY 2

Breakfast

.....

Lunch

.....

Dinner

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Snacks/Drinks

.....

DAY 3

Breakfast

.....

Lunch

.....

Dinner

.....

Snacks/Drinks

.....

CLIENT AND THERAPIST DECLARATION

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 them know that you are receiving nutritional therapy.

If you are receiving treatment from your GP, or any other medical provider, you should tell them 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 this document to be retained by both the client and the nutritional therapist)