Nutritional Therapy Questionnaire

Personal Details

Surname

First Name

Mr/Ms/Other

Telephone No.

Email

Address

Age Height Weight No. of children

Married Single Partner Divorced Separated Widow/er

Occupation

Who has referred you for your nutrition appointment?

Terms of Engagement

The Nutritional Therapist (NT) requests that the Client notes the following:

- The degree of benefit obtainable from Nutritional Therapy may vary between clients with similar health problems and following a similar Nutritional Therapy programme.
- Nutritional advice will be tailored to support health 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.
- Nuffield Health may recommend food supplements and/or functional testing as part of your Nutritional Therapy programme and may receive a commission on these products or services.
- Standards of professional practice in Nutritional Therapy are recognised through BANT and governed by the CNHC Code of Conduct.
- This document only covers the practice of Nutritional Therapy within this consultation, and your practitioner will make it clear if he or she intends to step outside this boundary.

The Client understands and agrees to the following:

- If I am receiving treatment from my GP, or any other medical provider, I should tell him/her about any nutritional strategy provided by my nutritional therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that I tell my nutritional therapist about any medical diagnosis, medication, herbal medicine, or food supplements, I am taking as this may affect the nutritional programme.
- If I am unclear about the agreed nutritional therapy programme/food supplement doses/time period, I should contact my nutritional therapist promptly for clarification.
- I must contact my nutritional therapist should I wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions.
- Recording consultations using any form of electronic media is not allowed without the written permission of both me and my Nutritional Therapist.

Client Name

Client Signature

Date

NT Name

NT Signature

Date

GP Details

GP Name

GP Address

GP Phone No.

Permission to contact GP? Yes No

Please check box if any of the following apply to you:

Severe/Persistent pain Head Abdomen Chest Eye Temple Passing Urine Any other

Bleeding (Blood in) Sputum Vomit Stool

Changes in Appetite Bowel Habit Passing Urine Skin Vision Personality/ Behaviour Body/ Face shape Breathing Swallowing

Please state below any medications that you are taking:

What health problems or operations have you had in the past?

Please summarise your family health history – illness/operations for grandparents/parents/siblings/children

Please list in priority order the health concerns that you wish to address	What management has been used so far: (GP/operation/medication/lifestyle etc.)	Length of concern

Drug Profile

	YES	NO	
Antibiotics			
Birth Control Pills			
Steroids			
Tranquillisers			
HRT			
Other Drugs			

Stress

How would you rate your current level of stress? Please tick from 1 (low stress) to 5 highly stressed

1 2 3 4 5

What Stresses are you under?

Energy Levels

How would you rate your energy levels? Please tick from 1 (low energy) to 5 (good energy levels)

1 2 3 4 5

When particularly do you experience low energy levels during the day?

Supplements

Do you take Nutritional Supplements? Please specify brands and dosage

Symptoms Questionnaire

Please tick those which apply to you

Blood sugar balance	Mild	Severe
Excess sweating	○	○
Drowsiness in the day	○	○
Poor concentration	○	○
Need for caffeine	○	○
Dizziness after 6 hours without food	○	○

Digestion		
Gas after eating	○	○
Heart burn	○	○
Nausea	○	○
Flatulence	○	○
<1 bowel move per day	○	○
Bloating	○	○
Diarrhoea	○	○
Constipation	○	○

Endocrine		
Night sweats	○	○
Insomnia	○	○
Racing heart	○	○
Frequent tiredness	○	○
Exhaustion after mild exercise	○	○
Sensitivity to cold	○	○
Easy weight gain	○	○
Frequent infections	○	○

Immune		
Nasal mucus	○	○
Frequent sore throats	○	○
Dark circles under eyes	○	○
Fluid retention	○	○
Hayfever	○	○
Watery/itchy eyes	○	○
Sinus or chest issues	○	○
Headaches	○	○
Migraines	○	○

Mood	Mild	Severe
Lack of enthusiasm for life	○	○
Anxiety	○	○
Depression	○	○
Irritability	○	○
Mood swings	○	○
Nervousness	○	○
Panic attacks	○	○

Musculo skeletal		
Joint pain	○	○
Rheumatic pain	○	○
Osteo arthritic joints	○	○
Reduced mobility	○	○

Skin/nails/hair		
Rosacea / acne	○	○
Psoriasis	○	○
Dry / cracked skin	○	○
Eczema	○	○
Ridged nails	○	○
White spots on nails	○	○
Oily hair	○	○
Brittle or thinning hair	○	○
Dandruff	○	○

Females only		
Heavy flow	○	○
Mood swings	○	○
Weight gain	○	○
Sweet cravings	○	○
Dizziness or fainting	○	○
Confusion/forgetfulness	○	○
Hot flushes	○	○

Men only		
Infertility	○	○
Urinary problems	○	○
Night waking to urinate	○	○

Food Diary

Please complete a three day food diary e.g. two weekdays and one weekend day, recording all foods and drinks consumed. Be as specific as possible, listing brands and quantities where appropriate. Please also record how each meal affects any food related health issues.

Day One

Time	Food/Drink Consumed	Comments/symptoms

Day Two

Time	Food/Drink Consumed	Comments/symptoms

Day Three

Time	Food/Drink Consumed	Comments/symptoms