NUTRITIONAL HEALTH QUESTIONNAIRE

Wendy Urwin
NUTRITION

This questionnaire is designed to provide the information required to create a personal health plan specifically tailored for your needs. **All information provided is treated in the strictest confidence.** Please answer the questions as fully as possible (using additional sheets if necessary), and return the completed questionnaire to Wendy Urwin Nutrition (Easter Crochail, Cannich, Inverness-shire IV4 7NE or wendy@wunutrition.co.uk) at least 3 days before your appointment. There is a blank page at the end any additional info you may wish to provide.

OFFICE USE ONLY	
DATE	
REF	

TITLE		NAME		DOB		AGE		☐ M ☐ F
ADDRESS								
EMAIL				HOME TEL		MOBILE		
OCCUPATION				MARITAL STATUS				
GP NAME & ADDRESS								
OTHER HEALTH PROFESSIONALS / THERAPISTS INVOLVED IN YOUR CARE:								
HOW DID YOU HEAR ABOUT US?								

HEALTH PROFILE

WHAT IS YOUR MAIN REASON FOR SEEKING NUTRITIONAL ADVICE?					
HEIGHT	WEIGHT		IS YOUR WEIGHT?	☐ STABLE	☐ INCREASING ☐ DECREASING
BMI	BLOOD PRESSURE	(if known)			

CURRENT HEALTH CONCERNS (please list in order of priority and continue on a separate page if necessary)	ONSET / DURATION
1.	
2.	
3.	
4.	
5.	

RECENT TEST RESULTS (within the last 12 months) – if possible please provide copy of test results.
DETAILS OF ANY PAST ILLNESSES, INFECTIONS OR OPERATIONS.

MEDICATION

MEDICATION	REASON FOR TAKING / CONDITION	HOW LONG HAVE YOU BEEN TAKING IT	DOSE/FREQUENCY
1.			
2.			
3.			
4.			
5.			
HAVE YOU EVER TAKEN ANTIBIOTICS? IF SO WHEN AND FOR HOW LONG?			

SUPPLEMENTS

SUPPLEMENT & BRAND	REASON FOR TAKING / CONDITION	HOW LONG HAVE YOU BEEN TAKING IT	DOSE/FREQUENCY
1.			
2.			
3.			
4.			
5.			

FAMILY HISTORY

HOW MANY CHILDREN DO YOU HAVE?	NUMBER	AGES
DAUGHTERS		
SONS		

FAMILY HISTORY – HEALTH SCREEN

Please Indicate If Any Of The Following Conditions Run In Your Family – (M=MALE; F=FEMALE)

CONDITION	GRANDPARENTS				PARENTS		SIBLINGS		CHILDREN	
	PATERNAL		MATERNAL							
	M	F	M	F	M	F	M	F	M	F
ARTHRITIS										
ASTHMA/ECZEMA/HAY FEVER										
CANCER										
DEPRESSION/OTHER MENTAL HEALTH PROBLEMS										
DEMENTIA										
DIABETES										
HEART DISEASE/STROKE/HIGH BP										
IBS										
CROHNS, COLITIS, COELIAC										
OBESITY										
OSTEOPOROSIS										

ANY OTHER FAMILY-RELATED ISSUES OF CONCERN TO YOU:

LIFE STYLE

DO YOU ENJOY YOUR DAILY LIFE?	Y / N	DO YOU WORK LONG / IRREGULAR HOURS?	Y / N
HOW MANY PEOPLE DEPEND ON YOU FOR SUPPORT?		ARE YOU UNDER ANY OTHER SIGNIFICANT STRESS?	Y / N
DO YOU FEEL SUPPORTED BY THE PEOPLE AROUND YOU?	Y / N	IS YOUR JOB / DAILY LIFE ACTIVE?	Y / N
ARE YOU RECENTLY BEREAVED / SEPARATED / DIVORCED /	Y / N	DO YOU SMOKE? IF SO, HOW MANY PER DAY?	
HAVE YOU MOVED HOUSE / CHANGED JOBS RECENTLY?	Y / N	DO YOU THINK YOU MAY BE ADDICTED TO ANYTHING?	Y / N

PLEASE RATE THE FOLLOWING USING THE SCALE BELOW:

HOW STRESSED YOU HAVE BEEN IN THE LAST MONTH?

LOW STRESS 1 2 3 4 5 6 7 8 9 10 HIGH STRESS

HOW MOTIVATED / CONFIDENT ARE YOU TO CHANGE YOUR DIET AND LIFESTYLE?

LOW MOTIVATION 1 2 3 4 5 6 7 8 9 10 HIGH MOTIVATION

DO YOU TAKE REGULAR EXERCISE? IF SO WHAT AND WHEN?

WHAT DO YOU DO FOR RELAXATION / HOBBIES?

WHAT TIME DO YOU USUALLY GO TO SLEEP / AWAKE?

DO YOU HAVE PROBLEMS SLEEPING? IF SO, PLEASE STATE:

SYMPTOM ANALYSIS

THIS SECTION AIMS TO PROVIDE YOUR PRACTITIONER WITH A GOOD OVERVIEW OF YOUR GENERAL STATE OF HEALTH AND AREAS THAT MAY NEED SUPPORT. PLEASE FILL IT IN AS WELL AS YOU CAN. THIS WILL FORM THE BASIS OF YOUR CONSULTATION AND WILL HELP US TO HELP YOU.

***PLEASE GRADE AS FOLLOWING:**

3= SEVERE/PERSISTENT, 2= MODERATE/REGULAR, 1= MILD/OCCASIONAL. LEAVE BLANK IF DOES NOT APPLY

PROFILE 1

ABDOMINAL BLOATING/DISCOMFORT WITHIN AN HOUR OF A MEAL OR A FEELING OF EXCESS FULLNESS	* e.g. 2	STOMACH UPSET BY TAKING VITAMINS	
DO NOT CHEW FOOD PROPERLY		STOMACH PAINS/CRAMPS	
HALITOSIS (BAD BREATH)		SLEEPY AFTER MEALS	
WEAK, PEELING, SPLIT OR RIDGED NAILS		DO YOU FEEL LIKE SKIPPING BREAKFAST?	
LOSS OF TASTE FOR MEAT		UNDIGESTED FOOD IN STOOLS	
HEARTBURN OR ACID REFLUX		BLACK OR TARRY STOOLS	
HISTORY OF ULCERS OR GASTRITIS		SOUR TASTE IN THE MOUTH	

PROFILE 2

INTOLERANCE TO ALCOHOL/EASILY INTOXICATED		SENSITIVE TO CHEMICALS, SMOKE, FUMES	
DIFFICULTY DIGESTING FATTY FOODS		HEADACHE OVER EYE	
NAUSEA		GREASY OR SHINY STOOLS	
PAIN BETWEEN SHOULDER BLADES		LIGHT OR CLAY-COLOURED STOOLS	
BITTER TASTE IN MOUTH ESPECIALLY AFTER MEALS		HAEMORRHOIDS	
YELLOWISH CAST TO SKIN OR EYES		LONG-TERM USE OF PRESCRIPTION MEDICATIONS	

PROFILE 3

FOOD ALLERGIES AND INTOLERANCES		MUCUS IN STOOL	
ABDOMINAL BLOATING 1 TO 2 HRS AFTER EATING		COATED TONGUE	
SINUS CONGESTION, STUFFY HEAD		ALTERNATING CONSTIPATION AND DIARRHOEA	
EXCESSIVE FLATULENCE		CONSTIPATION	
BIZARRE, VIVID OR NIGHTMARISH DREAMS		LESS THAN ONE BOWEL MOVEMENT DAILY	
FEEL SPACEY OR UNREAL		ANAL IRRITATION	

PROFILE 4

NEED MORE THAN 8 HOURS SLEEP A NIGHT		OFTEN FEEL DROWSY DURING THE DAY	
NEED/CRAVE TEA, COFFEE, CIGARETTES THROUGHOUT THE DAY		FUZZY THINKING, CONFUSION, OR DISORIENTATION	
IRRITABILITY, MOOD SWINGS OR FATIGUE IF A MEAL IS MISSED		OFTEN FEEL AGITATED, EASILY UPSET OR NERVOUS	
CRAVINGS FOR SWEET FOODS		HEADACHES IF MEALS ARE MISSED/DELAYED	
POOR MEMORY OR CONCENTRATION		BREATH SMELLS SWEET	
AVOID EXERCISE BECAUSE OF TIREDNESS		FREQUENT URINATION	
ENERGY LESS THAN IT USED TO BE		SWEAT A LOT OR GET EXCESSIVELY THIRSTY	

PROFILE 5

HARD TO GET UP IN THE MORNING		IMPATIENT OR INTOLERANT	
POOR SLEEP PATTERNS		APATHY AND DEPRESSION	
DIFFICULTY IN GETTING TO SLEEP		FEEL LIGHT-HEADED OR DIZZY ON STANDING	
ENERGY SLUMP DURING THE DAY, ESPECIALLY IN THE AFTERNOON		HIGHLY STRESSED OR LESS ABLE TO HANDLE STRESS	

PROFILE 5 (continued)

FEEL BETTER, MORE ALIVE IN THE EVENING		CRAVING FOR SALT/SALTY FOODS	
AGGRESSIVE OR ANGRY		FOOD ALLERGIES AND INTOLERANCES	
WORK OVER 50 HOURS PER WEEK		VERY COMPETITIVE/PERSISTENT NEED FOR ACHIEVEMENT	

PROFILE 6

FATIGUE, LETHARGY, POOR STAMINA		EXCESSIVE HAIR LOSS	
WEIGHT GAIN OR DIFFICULTY LOSING WEIGHT		OUTER THIRD OF EYEBROW THINS OR IS LOST	
FREQUENT DIETING		DEPRESSION, DIFFICULTY COPING	
COLD INTOLERANCE (HANDS OR FEET)		INFERTILITY	
LOW SWEATING		PMS OR MENSTRUAL IRREGULARITIES	
CHRONIC CONSTIPATION, IBS		REDUCED LIBIDO	
POOR DIGESTION, BLOATING		POOR CIRCULATION	
DRY SKIN AND/OR COARSE, DULL HAIR		POOR CONCENTRATION/MEMORY	
CARPEL TUNNEL SYNDROME		SHOULDER/NECK PAIN	
FIBROMYALGIA		MORNING HEADACHES – WEAR OFF DURING THE DAY	

PROFILE 7

JOB INVOLVES WORKING WITH CHEMICALS		DO NOT WASH FRUIT AND VEG. BEFORE EATING	
LIVE OR WORK IN A SMOKY ATMOSPHERE		USUALLY DRINK UNFILTERED TAP WATER	
LIVE IN A CITY OR NEAR A BUSY ROAD		DRINK MORE THAN ONE UNIT OF ALCOHOL PER DAY	
SPEND A LOT OF TIME IN FRONT OF VDU OR TV		MORE THAN THREE MERCURY AMALGAM FILLINGS	
USUALLY EAT NON-ORGANIC FOODS		USE RECREATIONAL DRUGS	

PROFILE 8

BONE DEFORMITIES		POORLY DEVELOPED MUSCLES	
BACK ACHE		LOSS OF MUSCLE TONE	
OSTEOPOROSIS/OSTEOPENIA		MUSCLE CRAMPS	
JOINT PAIN/STIFFNESS		MUSCLE SPASM/TINGLING	

PROFILE 9

CATCH MORE THAN THREE COLDS YEAR		FAMILY HISTORY OF CANCER	
PRONE TO RESPIRATORY INFECTIONS		INFLAMMATORY CONDITIONS - ECZEMA OR ASTHMA	
PRONE TO COLD SORES		SWOLLEN OR SORE GLANDS	
PRONE TO THRUSH OR CYSTITIS		ENVIRONMENTAL AND CHEMICAL SENSITIVITIES	
SUFFER FROM HAYFEVER		HISTORY OF ANTIBIOTIC USE	
SUFFER FROM ALLERGY PROBLEMS		HAVE RECENTLY TAKEN ANTIBIOTICS	

PROFILE 10

MIGRAINES		CONSTANT SORE THROAT	
FACIAL PUFFINESS		EARACHE	
ITCHY OR WATERY EYES		GLUE EAR	
EXCESSIVE SNEEZING		GENERAL JOINT PAIN OR STIFFNESS	
DARK CIRCLES UNDER EYES		TINNITUS	
SINUSITIS		EXCESSIVE MUCOUS	
GENERAL MUSCLE ACHES AND PAINS		HYPERACTIVITY	
FLUID RETENTION		ITCHY SKIN	
DIFFICULTY LOSING WEIGHT		PSORIASIS	

PROFILE 10 (continued)

DIFFICULTY GAINING WEIGHT		ECZEMA OR DERMATITIS	
RAPID WEIGHT FLUCTUATIONS		ASTHMA	
BINGE OR COMPULSIVE EATING		HAY FEVER	
FOOD CRAVINGS		HIVES	

IS YOUR URINE:
☐ COLOURLESS ☐ PALE YELLOW ☐ DARK YELLOW ☐ SMELLY ☐ CLOUDY ☐ OTHER COLOUR .....

FEMALE ONLY QUESTIONS

ARE YOU PREGNANT OR TRYING TO CONCEIVE?		PMS – ANXIETY, IRRITABILITY, TENSION, MOOD SWINGS	
ARE YOU BREASTFEEDING?		PMS – SWEET CRAVINGS, FATIGUE, HEADACHES	
HAVE YOU EVER HAD A MISCARRIAGE?		PMS – WEIGHT GAIN, BREAST TENDERNESS, BLOATING	
DO YOU GET THRUSH OR CYSTITIS?		PMS – DEPRESSION, CRYING, FORGETFULNESS	
ARE YOUR PERIODS REGULAR?		ARE YOU PERI-MENOPAUSAL?	
ARE YOUR PERIODS HEAVY?		ARE YOU POST-MENOPAUSAL?	
DO YOU HAVE HOT FLUSHES/NIGHT SWEATS?		DO YOU HAVE/HAVE YOU HAD FERTILITY PROBLEMS?	
DO YOU HAVE ENDOMETRIOSIS?		DO YOU HAVE UTERINE FIBROIDS	
DO YOU HAVE EXCESS FACIAL OR BODY HAIR?		DO YOU SUFFER FROM VAGINAL ITCHINESS?	

MALE ONLY QUESTIONS

PROSTATE PROBLEMS		WAKING TO URINATE AT NIGHT	
PAIN OR BURNING WITH URINATION		INTERRUPTION OF STREAM DURING URINATION	
FEELING OF INCOMPLETE BOWEL EVACUATION		DECREASED SEXUAL FUNCTION	
FERTILITY PROBLEMS		LOW SPERM COUNT	

PLEASE TICK IF YOU HAVE HAD ANY OF THE FOLLOWING IN THE LAST 6 MONTHS

UNEXPLAINED BLEEDING OR DISCHARGE FROM NIPPLE, VAGINA OR RECTUM BLOOD IN SPUTUM, VOMIT, URINE OR STOOLS BLACK, TARRY STOOLS BLEEDING IN PREGNANCY BREAST LUMPS CALF SWELLING PARALYSIS SLURRED SPEECH DEPRESSION/SUICIDAL THOUGHTS		PERSISTENT OR UNEXPLAINED PAIN PERSISTENT VOMITING OR DIARRHOEA DIFFICULTY SWALLOWING OR BREATHING EXCESSIVE THIRST INCREASED URINATION UNEXPLAINED WEIGHT LOSS LOSS OF APPETITE PAINLESS ULCERS OR FISSURES UNEXPLAINED BRUISING PERSISTENT COUGH	

ANY OTHER SYMPTOMS OR ISSUES NOT ALREADY COVERED THAT YOU FEEL ARE IMPORTANT

EATING HABITS

WHAT ARE YOUR FAVORITE FOODS?	
ARE THERE ANY FOODS YOU DISLIKE?	
DO YOU AVOID ANY FOODS FOR CULTURAL / ETHICAL REASONS? IF SO WHICH ONES	
ARE THERE ANY FOODS WHICH YOU CRAVE OR WOULD FIND IT DIFFICULT TO LIVE WITHOUT?	
ARE YOU SENSITIVE / ALLERGIC TO ANY FOODS? IF SO WHICH ONES	
DO ANY FOODS CAUSE DIGESTIVE PROBLEMS, IF SO WHICH ONES?	
DO YOU EVER HAVE EATING BINGES? IF SO WHAT DO YOU BINGE ON?	
WHO DOES THE COOKING IN YOUR HOUSEHOLD?	
DO YOU REGULARLY EAT ORGANIC:	☐ FRUIT ☐ VEGETABLES ☐ MEAT ☐ DAIRY
WHAT TYPE OF BREAD, RICE AND PASTA DO YOU USUALLY EAT?	BREAD: ☐ WHITE ☐ BROWN ☐ WHOLEMEAL ☐ GRANARY PASTA: ☐ WHITE ☐ WHOLEMEAL RICE: ☐ WHITE ☐ BROWN ☐ WILD

DO YOU EAT ON THE MOVE / WHEN STRESSED?	Y / N
DO YOU EAT AT REGULAR TIMES EACH DAY	Y / N
DO YOU REGULARLY MISS MEALS?	Y / N

DO YOU USE SALT IN YOUR COOKING / ADD IT TO YOUR FOOD?	Y / N
DO YOU HAVE SUGAR IN YOUR HOT DRINKS, IF SO HOW MANY SPOONFULS PER CUP?	
DO YOU ENJOY COOKING / FOOD PREPARATION?	Y / N

HOW MANY TIMES A WEEK DO YOU EAT:

RED MEAT (BEEF LAMB PORK GAME)	
PROCESSED MEATS (HAM BACON SAUSAGES HAMBURGERS)	
WHITE MEAT (CHICKEN TURKEY)	
WHITE FISH (COD HADDOCK POLLOCK)	
OILY FISH (SALMON TROUT TUNA HERRING MACKEREL)	

CHOCOLATE / SWEETS	
PUDDINGS	
CAKES / BISCUITS	
READY MEALS	
TAKE AWAYS / FAST FOOD	

HOW MANY TIMES A WEEK DO YOU DRINK:

FOR ALCOHOL CONSUMPTION PLEASE STATE NUMBER OF UNITS CONSUMED PER WEEK
(1 UNIT = 1 SMALL GLASS OF WINE, ½ PINT BEER / LAGER / CIDER OR 1 MEASURE OF SPIRITS)

RED / WHITE WINE	
SPIRITS	
COFFEE	

BEER / LAGER / CIDER	
CANNED FIZZY DRINKS	
TEA	

WHICH COOKING METHODS DO YOU GENERALLY USE?

☐ BOILING ☐ STEAM ☐ GRILLING ☐ DEEP- FRY ☐ SHALLOW FRY ☐ BAKE ☐ ROAST ☐ MICROWAVE

3 DAY FOOD DIARY

PLEASE CHOOSE 2 FAIRLY TYPICAL WEEKDAYS AND A WEEKEND / DAY OFF AND RECORD BELOW WHAT YOU ATE AND DRANK. PLEASE GIVE AS MUCH INFORMATION AS POSSIBLE – EG PORTION SIZE, HOME COOKED (IF SO PLEASE STATE INGREDIENTS) OR SHOP BOUGHT, BRAND NAMES, FRESH, ORGANIC, WHOLEGRAIN / WHOLE WHEAT OR WHITE ETC

	WEEKDAY 1		WEEKDAY 2		WEEKEND DAY / DAY OFF	
BREAKFAST	TIME:		TIME:		TIME:	
LUNCH	TIME:		TIME:		TIME:	
DINNER	TIME:		TIME:		TIME:	
SNACKS	TIME:		TIME:		TIME:	
DRINKS	COFFEE		COFFEE		COFFEE	
	'NORMAL' TEA		'NORMAL' TEA		'NORMAL' TEA	
	GREEN / HERBAL TEA		GREEN / HERBAL TEA		GREEN / HERBAL TEA	
	FIZZY DRINKS / CORDIALS		FIZZY DRINKS / CORDIALS		FIZZY DRINKS / CORDIALS	
	UNITS OF ALCOHOL* TYPE:		UNITS OF ALCOHOL* TYPE:		UNITS OF ALCOHOL* TYPE:	
	GLASSES OF WATER		GLASSES OF WATER		GLASSES OF WATER	
	OTHER DRINKS:		OTHER DRINKS:		OTHER DRINKS:	

* 1 UNIT = 1 SMALL GLASS OF WINE, ½ PINT BEER / LAGER / CIDER OR 1 MEASURE OF SPIRITS

TERMS OF ENGAGEMENT

(Issue 2.5 May 2015)

BETWEEN THE BANT NUTRITIONAL THERAPIST (NT) AND HIS/HER CLIENT

Please read and then sign and date the form below. If you have any queries please contact me.

The Nutritional Therapy Descriptor

Nutritional Therapy is the application of nutrition science in the promotion of health, peak performance and individual care. Nutritional therapy practitioners use a wide range of tools to assess and identify potential nutritional imbalances and understand how these may contribute to an individual's symptoms and health concerns. This approach allows them to work with individuals to address nutritional balance and help support the body towards maintaining health. Nutritional therapy is recognised as a complementary medicine and is relevant for individuals with chronic conditions, as well as those looking for support to enhance their health and wellbeing.

Practitioners consider each individual to be unique and recommend personalised nutrition and lifestyle programmes rather than a 'one size fits all' approach. Practitioners never recommend nutritional therapy as a replacement for medical advice and always refer any client with 'red flag' signs or symptoms to their medical professional. They will also frequently work alongside a medical professional and will communicate with other healthcare professionals involved in the client's care to explain any nutritional therapy programme that has been provided.

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.

• Your Nutritional Therapist 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 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:

• I am responsible for contacting my GP about any health concerns.

• I give permission for you to contact my GP regarding any agreed aspects of my case: YES ☐ NO ☐

• 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 understand that the advice is personal to me and may not be appropriate for others.

• 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.

We understand the above and agree that our professional relationship will be based on the content of this document. We declare that all the information we share during this professional relationship is confidential and to the best of our knowledge, true and correct. Client Name:

CLIENT NAME:	
CLIENT SIGNATURE:	
DATE:	

NT NAME:	
NT SIGNATURE:	
DATE:	

ADDITIONAL INFORMATION

IF NECESSARY, PLEASE USE THIS SHEET TO CONTINUE YOUR ANSWERS