

Nutritional Questionnaire

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Components of this questionnaire have been used over many years by Nutritional Therapists. I have added additional sections for the assessment of the nutritional influence upon brain chemistry, behaviour and for metabolic type.

Instructions: If you are not sure of an answer skip the question until you can clarify it at the consultation.

You may add extra information if you wish.

Title: _____ First Name: _____ Last Name: _____

Address: _____

Post Code: _____ email _____

Phone: (Home) _____ Work _____

(Mob): _____ Occupation: _____ Date of Birth: _____

Weight: (*without clothes*) _____ Height: (*without shoes*) _____

Blood Type (*if known*): _____ Name of Your G.P.: _____

Surgery Address: _____ Surgery Phone No: _____

List all medications you are taking: _____

HEALTH PROBLEMS

Please list the health problems you would like to clear up, and indicate how long you have suffered with them

	Health problem/s	Duration
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

List anything that improves your symptoms: _____

List anything that worsens your symptoms: _____

VITAMIN & FATTY ACID SYMPTOM ANALYSIS (Symptoms of deficiency)

Each group of symptoms relates to a particular nutrient. Bold type indicates a more important symptom.

Instructions: Underline symptoms you often experience. Some symptoms are repeated, underline them in all cases!

1.
Mouth Ulcers
Frequent colds or infection
Thrush or cystitis
Acne
Dandruff A/or Dry flaky skin
Poor night vision
Diarrhoea
2.
Tender muscles
Poor memory and/or concentration
Stomach pains
Constipation
Tingling hands
Prickly legs
Eye pains
Rapid heart beat
3.
Burning, bloodshot or gritty eyes
Sensitivity to bright lights
Dull or oily hair
Sore tongue
Cataracts
Split nails and/or cracked lips
Eczema or dermatitis
4.
Anxiety and/or tension
Depression and/or irritability
Headaches or migraines
Bleeding and/or tender gums
Insomnia
Lack of energy
Poor memory
Acne
Diarrhoea
5.
Burning feet or tender heels
Anxiety or tension
Teeth grinding
Lack of energy or apathy
Nausea or vomiting
Exhaustion after light exercise
Poor concentration
Muscle tremors, spasms or cramps
6.
Water retention
lack of energy
Depression or nervousness
Infrequent dream recall
Flaky skin
Irritability
Tingling hands
Cramps, Muscle tremors
7.
Lack of energy
Eczema or dermatitis
Poor hair condition
Irritability
Anxiety and/or tension
Constipation
Tender or sore muscles
Pale skin
Mouth over sensitive to hot or cold
8.
Lack of energy
Depression anxiety and/or tension
Poor memory
Prematurely greying hair
Poor appetite
Stomach pains
Cracked lips
9.
Poor appetite and/or nausea
Tender and/or sore muscles
Dry Skin
Eczema or dermatitis
Poor hair condition
Prematurely greying hair
10.
Frequent colds &/or infections
Slow wound healing.
Bleeding or tender gums
Nose bleeds
Easy bruising
Lack of energy
Red pimples on skin
11.
Rheumatism or arthritis
Joint stiffness or pain
Back ache
Tooth decay
Hair loss
Muscle cramps or spasms
Excessive swelling
Lack of energy
12.
Slow wound healing
Exhaustion after light exercise
Easy bruising
Lack of sex drive
Varicose veins Loss
of muscle tone
Infertility
13.
Dry skin and/or acne
Dermatitis or eczema or psoriasis
Cracked skin on fingertips or heels
'Chicken skin' on backs of arms
Patches of pale skin on cheeks
Dry eyes
Loss of hair or dandruff
Dry unmanageable hair
Soft or brittle nails
Excessive thirst and/or frequent
urination
PMS or breast pain and/or infertility
Frequent infections or lowered immunity
Poor wound healing
Poor memory and/or learning problems
A.D.D and/or hyperactivity and/or
irritability
Weakness or fatigue
Aching joints or arthritis
Allergies and/or inflammatory conditions
Cardiovascular disease
Depression/ Bipolar disorder

ESSENTIAL MINERAL SYMPTOM ANALYSIS (Symptoms of deficiency)

Instructions: Underline symptoms you often experience. *Some symptoms are repeated, underline them in all cases.*

1.
High Blood pressure
Joint pain
Arthritis
Tooth decay
Insomnia
Muscle cramps or tremors
Nervousness and/or irritability
Agitation or hyperactivity
Cognitive impairment
Osteoporosis or Rickets
Autism
2.
Excessive or cold sweats & thirst
Dizziness or irritability after 6 hours without food
'Addicted ' to sweet foods Cold hands
Need for frequent meals
Need for excessive sleep or drowsiness during the day
Cholesterol problems
3.
Epilepsy
Loss of hair pigment
Depression
Anaemia, fatigue
Immunity problems
4.
Pale skin
Heavy periods or blood loss
Fatigue or listlessness
Sore tongue
Loss of appetite or nausea
5.
Fatigue, weight gain
Thyroid problems and/or Goitre
Learning problems
Cretinism
6.
Alcohol problems
7.
Depression
Learning problems
Bipolar disorder
Aggression or violence
8.
Muscle tremors or spasms
Constipation
Fits or convulsions
Agitation, restlessness or irritability
Hyperactivity and/or ADHD
Insomnia, nervousness or anxiety
High blood pressure
Muscle weakness
Depression
Irregular heart beat
Neurological disorders
9.
Dizziness or poor sense of balance
Childhood' growing pains
Fits or convulsions
Sore knees
Muscle twitches
Poor growth of bones and/or connective tissues
Blood sugar problems
Behaviour problems
Allergies
Heart problems
Tinnitus *and/or* hearing loss
10.
Family history of cancer
Signs of premature ageing
Cataracts
Neurological problems
High blood pressure
Frequent infections
11.
Connective tissue problems
Cartilage problems
Varicose veins
Poor condition of nails and/or hair
Skin of finger tips cracked or split
Poor wound healing
Slow to heal infections
Septic conditions
12.
Stiff or aching joints
Arthritis or joint pain
Inflammation
Sports injury problems
Allergic tendency
Skin problems
13.
Behavioural problems
14.
White marks on fingernails
Poor sense of taste or smell
Anorexia
Stretch marks
Tendency to depression
Poor appetite
Acne or greasy skin
Poor wound healing
Low stomach acid
Night blindness
Frequent infections
Low fertility
Dyslexia
Retarded growth

TOXIC ELEMENT SYMPTOM ANALYSIS (Symptoms of excess)

Instructions: Underline symptoms you often experience. Some *symptoms are repeated, underline them in all cases.*

N.B. These are mostly non essential minerals (also known as "heavy metals"). Some of the essential minerals are repeated here with their symptoms of excess rather than deficiency.

- | | | |
|--|--|---|
| 1.
Headaches
Fatigue
Alzheimer's disease
Senility or dementia
Learning problems
Behavioural problems & hyperactivity
Bone pain
Irritation
Kidney and liver dysfunction | 5.
Fatigue or depression and apathy
Headaches and/or fevers/chills
M.S. symptoms or tremors
Poor concentration
Insomnia
Lowered libido
Excitability and/or irritability
Metallic taste in mouth
Increased salivation & (gastro-intestinal) problems | 9.
Anorexia or appetite loss
Mental confusion
Tremors
Hair loss
Hypertension

10.
Bi-polar disorder
Behavioural problems |
| 2.
Anorexia
Hair loss
White-streaked or brittle nails
Muscle pain, burning or tingling
Brain dysfunction, confusion
Fatigue
Seizures | 6.
Lowered I.Q.
Metallic taste in mouth
Insomnia A headache
Muscle pains
Irritability
Constipation
Learning and behavioural problems
Hyperactivity or aggression and/or violence
Anorexia or reduced appetite
Depression and/or fatigue
Low libido
Anaemia | 11.
Depression or hallucinations
Severe seizures in epilepsy
Nausea
Sweating
Intolerance to alcohol |
| 3.
Hypertension or hypotension
Bone/joint aches and pains
Lowered immunity or fatigue
Aggression or violence
Lowered I.Q. or learning problems
Anorexia, nausea, vomiting, diarrhoea
Osteomalacia, sore joints
Liver and kidney damage | 7.
Learning problems
Hypertension and headache
Neurological and movement disorders
Behavioural problems | |
| 4.
Dyslexia
Nervousness
Poor memory
Brain dysfunction
Bipolar disorder
Paranoia and hallucinations
Mental & physical fatigue
Depression & insomnia
Dermatitis or bronchial asthma
Addiction
Joint and muscle pain | 8.
Hair loss
Thickened and fragile nails
Fatigue and weakness
Lowered immunity
Garlic breath odour | |

LIFESTYLE AND BODY SYSTEMS ANALYSIS

Stress Profile

Please tick those symptoms that apply to you most days

Feel guilty when relaxing?
Work harder than most *people*?
Is your energy less now than it used to be?
Are you unclear about your goals in life or have difficulty making decisions?
Often do 2 or 3 tasks simultaneously?
Easily become angry or irritable?
Become impatient when people hold you up?
Mood swings?
Feeling that you can't cope or lack motivation?
Does it feel like there is never enough time?
Difficulty unwinding or getting off to sleep?
Wake up feeling anxious or very groggy?
Find it especially difficult to openly admit failure or defeat?
Have a persistent need for recognition or achievement?
Panic attacks?

Allergy Profile

Underline those that apply to you:

History of nasal problems, catarrh, hay fever, eczema, colic, dermatitis, asthma, headaches or migraine, irritable bowel syndrome (constipation or diarrhoea), wind, frequent bloatedness, facial puffiness, daily weight fluctuations, celiac disease, eat your favourite foods daily, mood swings, frequent and/or rapid onset of colds or infections, reaction to certain foods, hyperactivity, ADD or ADHD, learning or behavioural problems, irritability, frequent bouts of low energy or depression (worse after meals), addicted to or craving for certain foods/drinks, sleep problems, paranoia, not breast fed, dark circles under the eyes.

Pyroluria Profile

Underline those that apply to you: Intolerance to some protein foods, alcohol or drugs, feel better on vegetarian diet, nausea and constipation in the morning, rarely remember dreams, crowded upper front teeth (often only obvious in childhood), white spots on finger nails, pale and thin finger nails, pale skin that does not tolerate sun (does not tan easily), pain in upper abdomen, frequent colds and infections, stretch marks, distinct body and breath odour, irregular menstrual periods or impotency, higher risk of miscarriage of boys, insomnia, nervousness, depression, seek periods of seclusion and withdrawal, *any of above symptoms particularly when stressed*

Glucose Tolerance Profile

Please tick those symptoms that apply to you most days

Sleep problems at night.
Do you have or crave tea coffee, sugar containing drinks, snacks or cigarettes?
Often feel drowsy, faint or weak during the day?
Dizzy or irritable if you miss a meal?
Sweat for no apparent reason?
Feel thirsty a lot?
Fatigue in the day?
Energy levels fluctuate wildly?
Cold hands ?
Frequent headaches?
Frequently experience anxiety, nervousness, fearfulness or trembling?
Frequently experience depression, forgetfulness, confusion or poor concentration?
Difficulty digesting fatty foods?
Palpitations or blackouts?

Histamine Profile

Underline the following that apply to you: Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, fat or 'well covered' or fat in lower half of body, can tolerate pain, several dental fillings, do not suffer from headaches or allergies, suspicious by nature, ringing in the ears, seeing or hearing things abnormally, feeling that someone controls your mind, have ideas of grandeur, anxiety, paranoia, hallucinations. Or, Sleep less than 7 hours and/or light *sleeper*, strong sex drive, little body hair, family history of allergies, *experience* seasonal or regular allergies, fast metabolism, 'morning' person, long toes and fingers, large ears, experience headaches, backaches, stomach-aches, muscle cramps, tension and/or depression, don't put on weight, poor tolerance of pain, sneeze in bright sunlight, shy or very sensitive as a *teenager*, easily cry, easily salivate or feel nausea, hear your pulse in your head on your pillow at night, addictive by nature, can tolerate a lot of alcohol, belong to an all-boy family, obsessive, have a lot of fears, compulsions or rituals, higher risk of suicide.

LIFESTYLE AND BODY SYSTEMS ANALYSIS

Cardiovascular Profile

- _____ Is your blood pressure generally normal, high or low?
- _____ Is your pulse after resting for 15 minutes above 75 beats per minute?
- _____ Are you more than 14lbs (Tkg) over your ideal weight?
- _____ Do you smoke regularly?
- _____ Do you eat refined sugar daily
- _____ Do you usually add salt to your food?
- _____ Do you eat red meat more than 5 times a week?
- _____ Do you have alcoholic drinks every day?
- _____ Do you do less than 2 hours vigorous exercise a week (or one hour if over 50)?
- _____ Is your lifestyle very stressful?
- _____ Do you ever get palpitations or irregular heartbeats?

- _____ History of heart disease in your family?

Profile Digestion Profile

- _____ How many bowel movements per day?
- _____ Do you regularly miss going to the loo for one or more days?
- _____ Do you regularly have diarrhoea?
- _____ Do you suffer from flatulence/bloating?
- _____ Are you prone to stomach upsets?
- _____ Do you suffer from bad breath?
- _____ Do you suffer from heartburn or acidity?
- _____ Have you ever suffered from a digestive ulcer?
- _____ Difficulty digesting fatty foods?
- _____ Do you experience anal irritation?
- _____ Do you use indigestion tablets?
- _____ Have you ever taken antibiotics more than 3 x in one year or for long periods of time?

Hereditary Profile

List any health problems common in your family:

How many children do you have? State ages:

Medical History: List the illnesses or other symptoms including Serious accidents, injuries, surgery, radiation, drugs or other treatments you have had (continue over leaf if needed):

Immune Profile

- _____ Do you get more than 3 colds a year?
- _____ Do you find it hard to shift an infection?
- _____ Do you take antibiotics most years?
- _____ Are you prone to thrush or cystitis?
- _____ Is there a history of cancer in your family?
- _____ Have you ever had any growths or lumps biopsied?
- _____ Do you have an inflammatory disease such as eczema, asthma, or arthritis?

Exercise Profile

- Do you take vigorous exercise for less than 20 minutes 3 x a week?
- Does your job or lifestyle involve lots of walking or other forms of exercise?

- Do you play sports (football, squash etc.)?
- Do you have any active hobbies?
- Do you feel yourself to be fit or unfit?

Pollution Risk

- Do you live in a city or by a busy road?
- Do you smoke regularly?
- _____ Do you spend more than 2 hours a week in heavy traffic?
- Do you exercise by busy roads?
- _____ Do you live in an old or new house (built before of after 1940)?
- _____ Do you eat and drink mainly non organically grown produce?
- _____ Do you consume more than one alcoholic drink a day?
- _____ Do you use indigestion tablets?
- _____ Do you use aluminium, non stick or copper cooking pots and pans?
- Do you use a mobile phone every day, or for long periods of time?
- _____ Do you have more than 3 amalgam dental fillings that are more than five years old?

Additional Questions for Women

- _____ Are you pregnant? If so how many weeks? _____
- _____ Are you trying to become pregnant?
- _____ If so, how long have you been trying?
- _____ Have you ever had a miscarriage?
- _____ Do you have a I U D, or use the Pill?
- _____ Are your periods regular?
- _____ Are you menopausal or post menopausal?
- _____ Do you suffer from any of the following premenstrual symptoms; Please underline

- A. Anxiety, Depression, Irritability, Mood swings, Tension,
- B. Bloating, Oedema, Swelling, Breast Tenderness, Weight gain.
- C. Cravings (such as sweets or chocolate). Increased appetite. Headaches, Palpitations, Dizziness
- D. Depression, Crying, Confusion, Lethargy, Insomnia, Forgetfulness, Suicidal feelings.

DIET ANALYSIS

Please tick the questions to which you would answer 'yes' or answer the other questions as appropriate:

	Were you breast fed?		Do you normally eat white rice, bread or flour?
	Was a significant percentage of your diet as a child high in fatty foods?		How many cans of food do you eat per week?
	Do you go out of your way to avoid foods containing preservatives or additives?		How many slices of bread or rolls do you eat per week?
	Do you avoid foods that contain sugar?		How many pints of milk do you drink in a week?
	How many teaspoons of sugar do you add to food or drinks each day?		How many times a week do you eat red <i>meat</i> ?
	Do you use salt in your cooking?		How many times a week do you eat white meat?
	Do you add salt to your food?		What is your usual alcoholic drink?
	How many <i>coffees</i> do you drink a day?		How many glasses do you drink a week
	How many cups of tea do you drink each day?		How many times a week do you eat live yogurt?
	How many times a week do you have meals containing fried food?		Do you use filtered, bottled or tap water?
	How many packets of 'instant* or fast foods do you eat each week?		Do you frequently eat under stressful condition Or on the move?
	How many times a week do you eat chocolate or confectionery?		Does your job involve eating out a lot?
	What % of your diet is raw fruit/vegetables?		How would you describe your appetite? (a) poor (b) average (e) good

A Typical Days Food and Drink

Please write down details of your diet including approximate quantities and whether it is packaged or freshly made.

Breakfast:

Lunch:

Tea:

Supper:

Snacks, water and other drinks:

Please list all Nutritional, Herbal or other natural remedies you take daily or frequently:

Additional information on diet, health programme or other related areas (use over the page if needed):