NUTRITIONAL THERAPY QUESTIONNAIRE

inner health clinic

Please complete this questionnaire as fully and accurately as possible, and return prior to your consultation either by post to Ruth Tansey, 115 Petersburg Road, Edgeley, Stockport. SK3 9QZ or by e-mail to inner-health-clinic@hotmail.co.uk. If you have had any recent tests done through your GP or other healthcare provider it would be helpful if you could enclose/attach copies.

PERSONAL DETAILS

Title…… Name …….. Date of Birth……

Address ……

e-mail……Phone numbers……/……

GPs name and address ……

Weight…… Height…….. Waist circumference……

Blood pressure…… Cholesterol……

Occupation…….. Work environment (e.g. office, car)……..

HEALTH PROFILE

What is your main reason for seeking nutritional advice: ……

Please list any health concerns, their duration and management so far.

Health concern	Management e.g. medication including dose, surgery, complementary therapies, dietary supplements	Onset/duration
1.		
2.		
3.		
4.		
5.		

What seems to make your symptoms worse?

Do you take any other medications or supplements?

When did you last take antibiotics?

Have you had any recent health tests?

Do you suspect your symptoms relate to a particular event or time in your life?

HEALTH SYMPTOMS

Please rate symptoms by frequency and severity on a scale of 0 to 3, where

0 = no, symptom does not occur
1 = yes, minor or mild symptom and/or rarely occurs (monthly or less)
2 = moderate symptom and/or occurs occasionally (weekly)
3 = severe symptom and/or occurs frequently (daily or most days)

Digestive system	0	1	2	3	**Hair**	0	1	2	3
Nausea or vomiting	☐	☐	☐	☐	Hair loss	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	Dry hair	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	Oily hair	☐	☐	☐	☐
Bloating	☐	☐	☐	☐	Poor hair condition	☐	☐	☐	☐
Belching or flatulence	☐	☐	☐	☐	Decreased body hair	☐	☐	☐	☐
Heartburn	☐	☐	☐	☐	Increased facial hair	☐	☐	☐	☐
Acid reflux	☐	☐	☐	☐	Other	☐	☐	☐	☐
Pain/cramps	☐	☐	☐	☐					
Feeling full after meals	☐	☐	☐	☐	**Skin**				
Haemorrhoids	☐	☐	☐	☐	Dry	☐	☐	☐	☐
Urgency	☐	☐	☐	☐	Oily	☐	☐	☐	☐
Other	☐	☐	☐	☐	Eczema/dermatitis	☐	☐	☐	☐
					Hives or rashes	☐	☐	☐	☐
Mouth/throat					Acne	☐	☐	☐	☐
Sore tongue	☐	☐	☐	☐	Soft, cracked or brittle nails	☐	☐	☐	☐
Ulcers	☐	☐	☐	☐	Flushing/hot flushes	☐	☐	☐	☐
Bad breath	☐	☐	☐	☐	Excessive sweating	☐	☐	☐	☐
Sore throat	☐	☐	☐	☐	More than 2 white spots on fingernails	☐	☐	☐	☐
Cold sores	☐	☐	☐	☐	Other	☐	☐	☐	☐
Tooth decay	☐	☐	☐	☐					
Hoarseness	☐	☐	☐	☐	**Eyes**				
Bleeding gums	☐	☐	☐	☐	Puffy, swollen or red	☐	☐	☐	☐
Other	☐	☐	☐	☐	Watery or itchy	☐	☐	☐	☐
					Dark rings underneath or around eyes	☐	☐	☐	☐
Head					Other				
Headaches	☐	☐	☐	☐					
Migraines	☐	☐	☐	☐	**Senses**				
Dizziness	☐	☐	☐	☐	Sensitivity to bright lights	☐	☐	☐	☐
Poor balance	☐	☐	☐	☐	Sensitive to strong smells	☐	☐	☐	☐
"Brain fog"	☐	☐	☐	☐	Poor night vision	☐	☐	☐	☐
Blocked nose	☐	☐	☐	☐	Blurred vision	☐	☐	☐	☐
Prone to snoring	☐	☐	☐	☐	Poor hearing	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐	Tinnitus	☐	☐	☐	☐
Sneezing					Poor taste or smell	☐	☐	☐	☐
					Other	☐	☐	☐	☐

Joints/muscles					**Lungs**				
Painful or achy joints	☐	☐	☐	☐	Chronic cough	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	Shortness of breath	☐	☐	☐	☐
Stiffness	☐	☐	☐	☐	Wheezing	☐	☐	☐	☐
Weak or tired muscles	☐	☐	☐	☐	Asthma	☐	☐	☐	☐
Muscle cramps	☐	☐	☐	☐	Bronchitis	☐	☐	☐	☐
Restless legs	☐	☐	☐	☐	Frequent colds and chest infections	☐	☐	☐	☐
Other	☐	☐	☐	☐	Other	☐	☐	☐	☐
Mood					**Heart/circulation**				
Mood swings	☐	☐	☐	☐	Irregular or skipped heartbeat	☐	☐	☐	☐
Depression	☐	☐	☐	☐	Palpitation	☐	☐	☐	☐
Anxiety, fear or nervousness	☐	☐	☐	☐	Chest pain	☐	☐	☐	☐
Anger or aggressiveness	☐	☐	☐	☐	High blood pressure	☐	☐	☐	☐
Irritability	☐	☐	☐	☐	Cold hands and/or feet	☐	☐	☐	☐
Worried	☐	☐	☐	☐	Other	☐	☐	☐	☐
Other	☐	☐	☐	☐					
					Genitals/urinary				
Mind					Frequent or urgent urination	☐	☐	☐	☐
Poor concentration	☐	☐	☐	☐	Itch or discharge	☐	☐	☐	☐
Poor memory	☐	☐	☐	☐	Cystitis/thrush	☐	☐	☐	☐
Poor physical co-ordination	☐	☐	☐	☐	Prostate problem	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐	Other	☐	☐	☐	☐
Other	☐	☐	☐	☐					
					Women				
Energy					Menstrual pain	☐	☐	☐	☐
General fatigue	☐	☐	☐	☐	Irregular periods	☐	☐	☐	☐
Fluctuating energy levels	☐	☐	☐	☐	Premenstrual syndrome	☐	☐	☐	☐
Apathy/lethargy	☐	☐	☐	☐	Heavy periods	☐	☐	☐	☐
Hyperactive	☐	☐	☐	☐	Spotting between periods	☐	☐	☐	☐
Restless	☐	☐	☐	☐	Vaginal dryness	☐	☐	☐	☐
Feeling sluggish	☐	☐	☐	☐	Painful intercourse	☐	☐	☐	☐
Other	☐	☐	☐	☐	Painful/tender breasts	☐	☐	☐	☐
					Other	☐	☐	☐	☐
Miscellaneous									
Excessive thirst	☐	☐	☐	☐	Are you currently				
Numbness or tingling	☐	☐	☐	☐	Pregnant	☐			
Water retention	☐	☐	☐	☐	Trying to conceive	☐			
Loss of appetite	☐	☐	☐	☐	Breastfeeding	☐			
Compulsive eating/binge eating	☐	☐	☐	☐					
					How many children have you had?				
					Have you had any miscarriages?				
					Have you had any problems with fertility?				

Do you experience any of the following symptoms (*please tick*)

☐ Any persistent or unexplained pain

☐ Pain on passing urine (men)

☐ Cystitis recurring more than three times (women)

☐ Absence of pain in ulcers or fissures

☐ Sciatic pain associated with neurological deficit

☐ Blood in sputum, vomit, urine or stools

☐ Vomit containing "coffee grounds" (coagulated blood)

☐ Black, tarry stools

☐ Non-menstrual vaginal bleeding

☐ Vaginal bleeding with pain in pregnancy or after missing a period

☐ Deep depression with suicidal ideas

☐ Persisting vomiting and/or diarrhoea

☐ Persistent/excessive thirst

☐ Increased urination

☐ Persistent cough

☐ Unexplained weight loss

☐ Change in bowel habit

☐ Change in skin lesions

☐ Difficulty swallowing

☐ Difficulty breathing

☐ Pallor

☐ Unexplained swelling or lumps

☐ Unexplained fever

☐ Brown patches

MEDICAL HISTORY

Please list any major illnesses/operations/accidents or medical intervention that you have had, starting from childhood.

FAMILY HISTORY

Please list any illnesses or conditions on your father's or mother's side of the family, or of any siblings or children.

DIETARY HISTORY

Please also complete either the seven or three day food diary.

1. Do you have any dietary restrictions?
2. Do you have any food allergies/intolerances?
3. Do you crave any foods, and if so, which ones?
4. Which foods would you find hard to give up?
5. Which are your favourite foods?.
6. Which foods do you dislike?
7. Do you ever have eating binges, and if so, what do you binge on?
8. Do you often eat on the run or when you are stressed?
9. Do you use artificial sweeteners?
10. Do you add salt in your cooking or at the table?
11. Do you drink alcohol? If so, what is you main drink and how many units do you drink per week?
12. How much tea and coffee do you drink on a typical day?
13. How much water do you drink on a typical day?
14. How many soft drinks and juices do you drink on a typical day?
15. What percentage of your food is organic?

Food diary

Please choose a typical weekday and weekend day and list as completely and accurately as possible all your food and drinks intake. Please give as much detail as possible, e.g. home-cooked or not, brand names, fresh, wholemeal/refined, organic, etc. This will help you nutritional therapist to build a picture of your current diet.

	Time	Weekday/work day	Weekend/day-off
Breakfast			
Lunch			
Evening meal			
Snacks			
Non-alcoholic drinks			
Alcoholic drinks			

Have you recently made any changes to your diet? If so, what changes have you made?

LIFESTYLE HISTORY

1. How stressed are you on a scale of 1 to 10, where 1 is the lowest possible and 10 is the highest possible? C

2. Have you recently experienced any major stressful events?

3. What do you do to relax?

4. How much exercise do you do and what type?

5. Do you have any trouble sleeping?

6. How much sleep do you get?

7. Do you feel refreshed on waking?

8. Do you smoke, and if you do, how many?

9. Have you smoked in the past? If so, please indicate how much and when you stopped.

10. Do you have any occupational exposures?

11. How motivated/confident are you about changing your diet and lifestyle on a scale of 1 to 10, where 1 is low and 10 is high?

I have provided all the relevant information applicable to this consultation and my health status at this point in time.

I understand that any advice given should not be seen as a substitute for any medical treatment. I also understand that it is recommended that my GP is aware of any nutritional programme I follow.

Client signature Date

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE!

Ruth Tansey
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Nutritional Therapist
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