

HEALTH QUESTIONNAIRE

All details are private and confidential

Please complete this questionnaire comprehensively to enable your nutritional therapist to build an individualised nutritional programme.

**Please complete and return with cheque payment for your first appointment to:
Change Nutrition Ltd, 42 Newtown Road, Hove, BN3 6AB**

GENERAL INFORMATION

Today's Date:	How did you hear about Change Nutrition?
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BASIC DETAILS

Name:	Address:	Postcode:
Mr <input type="checkbox"/> Ms <input type="checkbox"/> Mrs <input type="checkbox"/>		Telephone (day):
Other <input type="checkbox"/>		
Telephone (evening) :	Email Address :	Occupation:
Date of Birth:	Height:	Weight:
Ethnicity:	Language:	Religion:
GP Name:	Practice Address:	GP Telephone No:

HEALTH STATUS

What are your main reasons for seeking Nutritional Therapy support at this time?

What are the other kinds of treatment or support (if any) you have tried so far?

Symptom Checklist

In some circumstances the following symptoms may indicate a need to be checked out by your GP/Consultant. Please tick all that apply. Symptoms will be discussed as part of your initial assessment.

<input type="checkbox"/> any unexplained pain <input type="checkbox"/> bleeding from nipple <input type="checkbox"/> women -non-menstrual bleeding from vagina <input type="checkbox"/> blood in sputum <input type="checkbox"/> blood in stool <input type="checkbox"/> blood in urine <input type="checkbox"/> blood in vomit <input type="checkbox"/> blurred vision or dizziness <input type="checkbox"/> breast lumps <input type="checkbox"/> calf swelling <input type="checkbox"/> change in nature of moles	<input type="checkbox"/> chest pain <input type="checkbox"/> constipation <input type="checkbox"/> depression <input type="checkbox"/> diarrhoea <input type="checkbox"/> difficulty swallowing <input type="checkbox"/> discharge from vagina <input type="checkbox"/> excessive thirst <input type="checkbox"/> frequent urination <input type="checkbox"/> headaches <input type="checkbox"/> inability to gain weight <input type="checkbox"/> loss of appetite	<input type="checkbox"/> numbness <input type="checkbox"/> paralysis <input type="checkbox"/> persistent cough <input type="checkbox"/> persistent nose bleeds <input type="checkbox"/> shortness of breath <input type="checkbox"/> slurred speech <input type="checkbox"/> unexplained bruising <input type="checkbox"/> unexplained heavy periods <input type="checkbox"/> unexplained loss of periods <input type="checkbox"/> unexplained rash <input type="checkbox"/> unexplained weight loss
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Do you give permission for your GP to be contacted as part of the consultation process?
 Yes: No I would like to discuss this further when we meet

Please list any other health professionals/therapists involved in your current care?
 (please continue on an additional sheet if more space is needed)

Name:	Role:
Name:	Role:
Name:	Role:

FAMILY HISTORY

Please list any diseases or health conditions associated with your family including parents, grandparents, aunts, uncles, siblings and own children (e.g. asthma, diabetes, drug/alcohol addictions, heart disease, mental health problems, endometriosis, fibroids, cancer, migraine, excema, coeliac, arthritis, ulcerative colitis , depressionetc)

Relationship (mother, sister, father, son,etc)	Condition(s)

Please list any other information you feel is relevant about your family or personal history :

SYSTEM CHECK

(please tick all that apply)

<p style="text-align: center;">WEIGHT</p> <input type="checkbox"/> fluctuating weight <input type="checkbox"/> fast metabolism <input type="checkbox"/> inability to gain weight <input type="checkbox"/> inability to lose weight <input type="checkbox"/> sudden weight loss <input type="checkbox"/> unexplained weight loss <input type="checkbox"/> unhappy with weight <input type="checkbox"/> water retention weight gain to: <input type="checkbox"/> central abdomen/stomach <input type="checkbox"/> hips and thighs <input type="checkbox"/> general	<p style="text-align: center;">SLEEP</p> <input type="checkbox"/> Poor dream recall <input type="checkbox"/> difficulty waking up <input type="checkbox"/> disordered sleeping pattern <input type="checkbox"/> feel sleepy during the day <input type="checkbox"/> feel tired all the time <input type="checkbox"/> feel un-refreshed after sleep <input type="checkbox"/> insomniac <input type="checkbox"/> need less than 7 hours sleep <input type="checkbox"/> need more than 8 hours sleep <input type="checkbox"/> shift worker <input type="checkbox"/> wake up during the night	<p style="text-align: center;">MOOD</p> <input type="checkbox"/> aggression/anger <input type="checkbox"/> anxiety <input type="checkbox"/> apathetic <input type="checkbox"/> competitive <input type="checkbox"/> depression <input type="checkbox"/> easily provoked <input type="checkbox"/> easily satisfied <input type="checkbox"/> hyperactive <input type="checkbox"/> irritability <input type="checkbox"/> mood swings <input type="checkbox"/> passive <input type="checkbox"/> tense
<p style="text-align: center;">ENERGY</p> <input type="checkbox"/> best in evenings <input type="checkbox"/> best in mornings <input type="checkbox"/> difficulty getting to sleep <input type="checkbox"/> difficulty getting up <input type="checkbox"/> exhaustion <input type="checkbox"/> fatigue <input type="checkbox"/> feel tired all the time <input type="checkbox"/> fluctuating energy in day <input type="checkbox"/> hyperactivity <input type="checkbox"/> lethargic <input type="checkbox"/> low energy	<p style="text-align: center;">DIGESTION & ABSORPTION</p> <input type="checkbox"/> bloating <input type="checkbox"/> eat quickly <input type="checkbox"/> can't tolerate fatty meals <input type="checkbox"/> eat on the move <input type="checkbox"/> eat when stressed <input type="checkbox"/> flatulence/wind <input type="checkbox"/> heartburn <input type="checkbox"/> indigestion <input type="checkbox"/> reflux <input type="checkbox"/> cramps	<p style="text-align: center;">ELIMINATION</p> <input type="checkbox"/> anal irritation <input type="checkbox"/> blood/black stool <input type="checkbox"/> constipation <input type="checkbox"/> infrequent bowel action <input type="checkbox"/> offensive stool <input type="checkbox"/> undigested food in stool <input type="checkbox"/> stools that float <input type="checkbox"/> diarrhoea <input type="checkbox"/> hemorrhoids <input type="checkbox"/> mucus in stool
<input type="checkbox"/> acne <input type="checkbox"/> arthritis <input type="checkbox"/> asthma <input type="checkbox"/> bronchitis <input type="checkbox"/> cancer <input type="checkbox"/> cardiovascular disease <input type="checkbox"/> conjunctivitis <input type="checkbox"/> Inflamm. Bowel disease (IBD) <input type="checkbox"/> cystitis	<p style="text-align: center;">INFLAMMATION</p> <input type="checkbox"/> eczema <input type="checkbox"/> food allergy/intolerance <input type="checkbox"/> gastritis <input type="checkbox"/> gingivitis <input type="checkbox"/> hayfever <input type="checkbox"/> hepatitis <input type="checkbox"/> hives <input type="checkbox"/> IBS <input type="checkbox"/> frequent infections	<input type="checkbox"/> prostatitis <input type="checkbox"/> psoriasis <input type="checkbox"/> rhinitis <input type="checkbox"/> sinusitis <input type="checkbox"/> SLE (lupus) <input type="checkbox"/> ulcers <input type="checkbox"/> urethritis <input type="checkbox"/> joint pains <input type="checkbox"/> mastitis <input type="checkbox"/> dermatitis
<input type="checkbox"/> additives and preservatives <input type="checkbox"/> anal itching <input type="checkbox"/> joint pains <input type="checkbox"/> caffeine keeps you awake <input type="checkbox"/> cellulite <input type="checkbox"/> chronic headaches <input type="checkbox"/> coated tongue <input type="checkbox"/> constipation <input type="checkbox"/> dark circles under the eyes <input type="checkbox"/> dark coloured/scant urine <input type="checkbox"/> dehydration <input type="checkbox"/> drug use (inc. recreational) <input type="checkbox"/> exercise by busy main roads <input type="checkbox"/> 'hangover' feeling	<p style="text-align: center;">DETOXIFICATION</p> <input type="checkbox"/> exposure to moulds <input type="checkbox"/> hormone problems <input type="checkbox"/> irritability <input type="checkbox"/> lethargy <input type="checkbox"/> low fruit & vegetable intake <input type="checkbox"/> live in a polluted area <input type="checkbox"/> low fibre intake <input type="checkbox"/> yellow tinge to skin/eyes <input type="checkbox"/> mercury fillings <input type="checkbox"/> muscle aches <input type="checkbox"/> nail infections <input type="checkbox"/> offensive body odour <input type="checkbox"/> offensive breath <input type="checkbox"/> offensive stools/urine	<input type="checkbox"/> regular alcohol <input type="checkbox"/> sensitivity to chemicals <input type="checkbox"/> signs of premature ageing <input type="checkbox"/> smoker <input type="checkbox"/> thrush/athletes foot <input type="checkbox"/> traveller's diarrhoea <input type="checkbox"/> unexplained itching/rashes <input type="checkbox"/> use garden chemicals <input type="checkbox"/> verruca/warts <input type="checkbox"/> unwashed fruit and veg. <input type="checkbox"/> water retention <input type="checkbox"/> work with chemicals/paint <input type="checkbox"/> worms or parasites

Allergy (please tick all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> fatigue | <input type="checkbox"/> irritable bowel |
| <input type="checkbox"/> asthma | <input type="checkbox"/> flatulence | <input type="checkbox"/> itchy eyes |
| <input type="checkbox"/> bloating | <input type="checkbox"/> fluctuating weight | <input type="checkbox"/> itchy skin |
| <input type="checkbox"/> chronic diarrhoea | <input type="checkbox"/> 'foggy brain' | <input type="checkbox"/> itchy throat |
| <input type="checkbox"/> constipation | <input type="checkbox"/> genital itch | <input type="checkbox"/> joint aches |
| <input type="checkbox"/> dark circles under eyes | <input type="checkbox"/> hayfever | <input type="checkbox"/> learning difficulties |
| <input type="checkbox"/> depression | <input type="checkbox"/> headaches | <input type="checkbox"/> lethargy |
| <input type="checkbox"/> eczema | <input type="checkbox"/> hives | <input type="checkbox"/> migraines |
| <input type="checkbox"/> excess mucus | <input type="checkbox"/> hyperactivity | <input type="checkbox"/> mood swings |
| <input type="checkbox"/> poor memory | <input type="checkbox"/> indigestion | <input type="checkbox"/> mouth ulcers |
| <input type="checkbox"/> psoriasis | <input type="checkbox"/> inflammation | <input type="checkbox"/> muscle aches |
| <input type="checkbox"/> rhinitis | <input type="checkbox"/> swollen lips | <input type="checkbox"/> palpitations |
| <input type="checkbox"/> skin rashes | <input type="checkbox"/> swollen throat | <input type="checkbox"/> poor concentration |
| <input type="checkbox"/> sneezing | <input type="checkbox"/> tension | <input type="checkbox"/> insomnia |
| | <input type="checkbox"/> watery eyes | <input type="checkbox"/> water retention |

Do you have a diagnosed allergy to any foods or other substances Yes No
 If yes, please give details:

Have you been tested for allergies or food intolerance/sensitivity? Yes No
 If yes, please give details of any findings:

Hormonal Balance- Women (please tick all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> PMS | <input type="checkbox"/> HRT | <input type="checkbox"/> Breast/Ovarian Cancer |
| <input type="checkbox"/> Painful periods | <input type="checkbox"/> Polycystic Ovaries | <input type="checkbox"/> Fertility problems |
| <input type="checkbox"/> Combined Pill | <input type="checkbox"/> Fibroids | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Mini/Progesterone only Pill | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Infrequent periods | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Thyroid condition | | |

Age at first period: _____ Age of final period if post menopause: _____

Details of any hormonal related conditions/issues if relevant for you

Are you currently pregnant or aiming to become pregnant? Yes No Unsure
 Additional information:

Hormonal Balance- Men (please tick all that apply)

- | | | |
|--|--|--|
| <input type="checkbox"/> Prostate Disorder | <input type="checkbox"/> Impotence | <input type="checkbox"/> Low libido |
| <input type="checkbox"/> Infertility | <input type="checkbox"/> Testicular Cancer | <input type="checkbox"/> Thyroid condition |

Details of any hormonal issues/further information

Circulation (please tick all that apply)

- abdominal weight gain
- anaemia
- angina
- atherosclerosis
- blue extremities
- headaches
- high blood pressure
- high cholesterol
- high triglycerides

- diabetes
- excessive exercise
- feel cold
- feel faint on standing
- feel hot
- feel stressed
- varicose veins
- water retention
- weight gain

- high fat diet
- minimal exercise
- obesity
- over-committed
- red face
- shortness of breath
- smoker – in past
- smoker – current
- sugary foods
- thread veins

Any additional information:

Activity Levels

In the daytime are you Active Moderately active Desk based/sedentary

Evenings and Weekend activity: Active Moderately active Mainly sedentary

Please describe your current level of exercise

Food Patterns and Diet (please tick all that apply)

What are your favourite foods?

Please list any foods that you crave

What are your least favourite foods?

Which foods would you find it most difficult to give up?

Have you had, or do you currently have, an eating disorder? Yes No Not sure

If yes, please add any details you feel are important

Would you say you are someone who 'eats to live' OR 'lives to eat' ?

Which of the following do you eat/drink regularly?

- | | | |
|---|---|---|
| <input type="checkbox"/> Tea | <input type="checkbox"/> Pre-prepared foods/salad | <input type="checkbox"/> Lentils and pulses |
| <input type="checkbox"/> Coffee | <input type="checkbox"/> Ready Meals | <input type="checkbox"/> Water – tap |
| <input type="checkbox"/> Herbal tea | <input type="checkbox"/> Restaurant meals | <input type="checkbox"/> Water – bottled/filtered |
| <input type="checkbox"/> Wheat-pasta,bread etc | <input type="checkbox"/> Fried foods | <input type="checkbox"/> Red meat |
| <input type="checkbox"/> Milk | <input type="checkbox"/> Barbequed food | <input type="checkbox"/> Chicken and poultry |
| <input type="checkbox"/> Cheese | <input type="checkbox"/> Nuts | <input type="checkbox"/> Eggs |
| <input type="checkbox"/> Yoghurt | <input type="checkbox"/> Seeds | <input type="checkbox"/> Biscuits |
| <input type="checkbox"/> Soya milk & products | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Pastries and cakes |
| <input type="checkbox"/> Green leafy vegetables | <input type="checkbox"/> Sweets | <input type="checkbox"/> Wine |
| <input type="checkbox"/> Salad leaves | <input type="checkbox"/> Margarine | <input type="checkbox"/> Beer |
| <input type="checkbox"/> Other vegetables | <input type="checkbox"/> Butter | <input type="checkbox"/> Spirits |
| <input type="checkbox"/> Fruit- berries | <input type="checkbox"/> Olive oil | <input type="checkbox"/> Pickles |
| <input type="checkbox"/> Fruit – general | <input type="checkbox"/> Other oils | <input type="checkbox"/> Oily Fish |
| <input type="checkbox"/> Rice | <input type="checkbox"/> Ketchups/sauces | <input type="checkbox"/> White fish |
| <input type="checkbox"/> Takeaways | | |

How many cups of tea and coffee do you have on an average day?

How many portions of red meat do you eat in a week?

How many portions of fish do you eat in a week?

How many portions of fruit do you eat in a day ? (a portion =size of a medium apple)

How many portions of vegetables do you eat in a day ? (a portions =size of a medium apple)

How many eggs do you have in a week?

How many units of alcohol in a week? (A unit is approx ½ a pint of beer/ small [125ml] glass of wine)

How many biscuits/cakes/chocolate bars/sweet snacks do you have in a day?

Are you following a special diet Yes No
If Yes , please give details

Which of the following best describes your lifestyle in relation to food? (tick one)

- 1) I cook meals most days using fresh foods
- 2) I cook a few times a week and have ready meals/takeaways or eat out for the rest
- 3) I rarely cook and prefer eating out or picking up convenience foods/ready meals

I confirm that to the best of my knowledge the information stated on this questionnaire is correct

Signed **Name:**..... **Date:**

Please now complete the 4 day food diary sheet on the final page then return your questionnaire to Change Nutrition at the address on the front page to arrive at least 5 working days before your appointment. Please note that the Initial Assessment appointment can only proceed once the completed health check questionnaire has been returned.

4 Day Food Diary

Please complete the 4 day 'food diary' showing your usual eating patterns in the week and at the weekend . *eg. 8 a.m. large bowl cornflakes with milk and a cup of tea ; 9am large cappuccino*

Weekday 1	Weekday 2
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks	Snacks
Drinks	Drinks
Saturday	Sunday
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks	Snacks
Drinks	Drinks