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Nutrition Health Questionnaire

PERSONAL DETAILS		**DATE:**
Name:		
Address:		
Home Phone:		Cell:
Email:		Date of Birth:
Occupation:		Full-time: ◯ Part-time: ◯
Age & sex of children:		
Age & sex of brothers & sisters:		
Height:	Weight:	Body shape:
Dress/suite size:	Desired size:	Eye color:
Hair color:	Texture:	Dyed:

MEDICAL HISTORY	
What medications do you take?	
Do you have any allergies to medication?	
What operations have you had and when?	
What accidents have you have and when?	
What childhood illnesses have you had and when?	
Did you have a normal delivery at birth?	
What is your blood pressure?	
What medical tests have you had in the last 2 years?	
Your Doctor's name and telephone number:	
Other therapies experienced:	
What illnesses are/were your parents prone to?	

HEALTH PROBLEMS THAT YOU WANT ADDRESSING

SYMPTOM CHECKLIST

Please score symptoms you are currently suffering on a scale of 1 to 3, 3 being the worst or more severe, leave blank if 0 score.

Digestion		**Ears/Eyes**	
	Nausea		Itchy ears
	Bloating		Ringing in ears
	Stomach pains		Ear aches
	Heartburns		Hearing loss
	Bad breath		Itchy eyes
	IBS		Watery/dry eyes
	Flatulence/wind		Dark circles under eyes
	Burping		Eye pain
Elimination		**Skin/Hair/Nails**	
	Diarrhea		Itchy/dry/flaky
	Daily bowel movement		Hot flushes
	Strain when eliminate		Pale skin
	Blood/mucous in stool		Eczema/psoriasis
	Anal irritation		Cracked lips
	Foul-smelling stool		Split nails
			acne
Heart			Red pimples on arms
	Low/high blood pressure		Ridges on nails
	Irregular heartbeat		Dull/oily hair
	Rapid pounding heart		Hair loss
	Chest pain		
Joint & Muscles		**Immune Profile**	
	Pains/aches in joints		Get many colds/flu
	Pains/aches in muscles		Sore throat/cough
	Stiffness		Cystitis
	Swollen joints		Candida
	Muscle cramps/spasms		History of cancer in family
	Muscle twitches		Breastfed as baby
	Backache		White marks on nails
Hormone Profile			Mouth ulcers
	Menstrual problems		Had any biopsies
	Regular periods		Use antibiotics 2x a year
	Pms		Slow wound healing
	Menopausal problems		Tooth decay
	Had a miscarriage		Any teeth/gum problems
	Use birth control pill/HRT	**Respiratory**	
	Lack of sex drive		Sinus problems
	Infertility		Wheezing
	Post-menopausal		Shortness of breath
			Sneezing/hay fever

Miscellaneous			
	Insomnia		Excessive thirst
	Headaches/migraines		Poor memory
	Crave sweet/savory food		Depression
	Lack of energy		Poor concentration
	Feel stressed		Hyperactivity
	Irritability/anxiety/tension		Hard to get going in morning
	Feel drowsy during day		Avoid exercise due to tiredness
	Dizziness		Mood swings
	Cold sweats		Water retention
Lifestyle (rate on a scale of 0-3)			
Do you:			
	Smoke?		Spend much time in front of TV/VDU?
	Live/work in a smokey atmosphere?		Eat compulsively?
	Exercise 3x weekly that increase heart rate?		Binge eat?
	Play a sport, if so what?		Have your meals sitting a table?
	Live in a city?		Have your meals watching TV?
	Have any know food allergies, if so what?		Eat out a lot?
	Have any environmental allergies?		Take recreational drugs?
Diet (rate on scale 0-3)			
	Do you generally eat organic food?		Do you drink filtered/bottled water
	Do you have regular meals?		Do you have breakfast
	Are you vegetarian		How good is your appetite (1-poor 2-ave 3-good)
	Do you wash fruit/veg		Do you use sugar in drinks or on food
	Do you have addiction to certain food, if yes what?		
	Do you drink alcohol, if yes what and how much?		
	Do you use convenience/prepared food?		
	How many slices of bread do you eat weekly, what type?		
	How much milk do you drink weekly, what type?		
	Do you eat eggs, how many a week?		
	How many times a week do you eat pasta?		
	How many times a week do you eat beans/lintels?		
	Check if you eat meat ☐ poultry ☐ fish ☐		
Supplements (List what supplements you are currently taking)			

Please list what type of food you typically eat. Be specific and detailed as possible	
Breakfast	**Lunch**
Dinner	**Snacks**
Drinks	