

**SCHOOL OF ALLIED HEALTH AND COMMUNITY**

**NUTRITIONAL THERAPY CLINIC CONFIDENTIAL CLIENT QUESTIONNAIRE**

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| **DATE** |  | **CLIENT NUMBER** |  |
| **FULL** **NAME** |  | **TITLE** |  |
| **ADDRESS** |  | **EMAIL ADRESS** |  |
| **TELEPHONE****NUMBER** |  | **PREFERRED METHOD AND** **TIME OF CONTACT**  |  |
| **GP NAME AND ADDRESS****(OPTIONAL)**  |  |

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| **weight** | **Height** | **blood pressure**(*If known*) | **Gender****(** *highlight or circle****)*** | **DOB/Age**  |
|  |  |  | **male/female** |  |
| **Married/Single/partner** |  | **Children**  | **Other dependants** | **Smoking**  |
|  |  |  | **Yes/No** |
| **Previous Occupation/s** |  |
| **Occupation****(Full or Part time)** |  |  |
| **PLEASE DESCRIBE BRIEFLY THE CONDITION(S) WHICH YOU WOULD LIKE SOME HELP WITH: INCLUDE ANY RECENT GP TEST RESULTS IF YOU HAVE THEM**  |
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| This the Nutritional Therapy “Red Flag” symptom list, which, if you have any of these symptoms, may indicate that you need to consult your GP or other health care practitioner if you have not already done so. If you tick that you have any of the symptoms below, we will discuss in the consultation.  |
| DO YOU HAVE ANY PERSISTENT PAIN IN ANY OF THE FOLLOWING (*Please tick any which apply to you)* |
| Head |  | Abdomen |  | Chest |  | Eye |  |
| Temple |  | On passing urine |  | Other (*please state*) |  |
| **DO YOU EVER GET BLOOD IN ANY OF THE FOLLOWING:** (*Please tick any which apply to you*) |
| Vomit |  | Stools |  | Urine |  | Sputum |  |
| **HAVE YOU RECENTLY NOTICED ANY CHANGES IN:** (*Please tick any which apply to you*) |
| Level of Thirst |  | Weight |  | Appetite |  | Skin |  |
| Vision |  | Digestion or Bowel Movements |  | Urination |  | Waist Size |  |
| Body / Face Shape |  | Swallowing |  | Breathing |  | Personality / Mood |  |

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| **HEALTH HISTORY**Please list any ***serious*** illnesses, health conditions, accidents or operations you have had plus courses of antibiotics if any (*please include childhood*) |
| illness, health condition, accident or operation | MEDICAL TREATMENT RECEIVED  | APPPROXIMATE DATE OR ONGOING  |
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| **PLEASE LIST ALL PRESCRIBED MEDICATIONS YOU CURRENTLY TAKE. IF IT IS EASIER ATTACH YOUR PRESCRIPTION (** *include pills, injections, patches or other devices*) |
| **name of medication** | **dose** | **length of time taken and reason**  |
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| **PLEASE LIST ANY OVER THE COUNTER MEDICATIONS and NUTRITIONAL SUPPLEMENTS THAT YOU REGULARLY TAKE**(*Including. antacids, pain relief pills, anti-histamines, anti-inflammatory drugs, herbal & nutritional supplements*). |
| **name of over the counter medication/supplement**  | **dose** | **length of time taken and reason** |
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| **HEALTH SCREEN - FAMILY HISTORY***Please indicate if any of the following conditions have occurred in your family - (M = Male; Fe =Female)* |
| **Condition** | **Grandparents** | **Parents** | **Siblings** | **Children** |
| **Paternal** | **Maternal** |
| **M** | **Fe** | **M** | **Fe** | **M** | **Fe** | **M** | **Fe** | **M** | **Fe** |
| Alcoholism |  |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |  |
| Asthma / Eczema / Hay fever |  |  |  |  |  |  |  |  |  |  |
| Autoimmune Condition |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |
| Alzheimer’s/Dementia |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |
| Heart Disease / Stroke / High Blood Pressure |  |  |  |  |  |  |  |  |  |  |
| IBS |  |  |  |  |  |  |  |  |  |  |
| Crohn’s, Colitis, Coeliac |  |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |  |

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| **ANY FURTHER NOTES ON FAMILY MEDICAL HISTORY** |
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| **DO YOU EXERCISE REGULARLY?** |  | **yes** |  | **no** |  |  |
|  |  |
| **WHAT TYPE OF EXERCISE DO YOU DO?** |
|  |
| **WHAT DO YOU DO TO RELAX?** |
|  |
| **TYPICAL STRESS LEVELS** *(highlight or circle as appropriate)* |
| **Low** | **High** |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| **EATING PATTERN** *(where do you eat, and approximately what times of the day )* |
|  |
| **SHOPPING** *(where, how, who…..)* |
|  |
| **APPROXIMATELY HOW MUCH DO YOU SPEND A WEEK ON FOOD?**  |  |
| **ARE YOU PREPARED TO SPEND ANYMORE AND IF SO HOW MUCH?** |  |
| **COOKING** *(who…..)* |
|  |
| **DESCRIBE YOUR APPETITE**  |
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| **HOW IS YOUR SLEEP?**  |
|  |
| **HOW IS YOUR WEIGHT MANAGEMENT ?** |
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| **please mention anything else you think might be relevant**  |
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| **SYMPTOM SCAN** |
| **The details given here will help your therapist to work on your case so please give as much detail as you can; the boxes will expand as you type into them and *leave blank* anything not applicable.**  |
|  | Severity of symptoms on a scale of 1-10 where 1 is mild and 10 is as bad as it can be  | Approximate date you first noticed the symptoms  | Additional comments  |
| **HEAD** |
| Headaches/Migraines |  |  |  |
| Fuzzy head |  |  |  |
| Dizzy |  |  |  |
| Poor balance |  |  |  |
| Easily intoxicated by alcohol |  |  |  |
| Other  |  |  |  |
| HAIR |  |  |  |
| Oily |  |  |  |
| Dry |  |  |  |
| Thin /thinning |  |  |  |
| Other |  |  |  |
| MOUTH |  |  |  |
| Sore tongue |  |  |  |
| Sore throat |  |  |  |
| Ulcers |  |  |  |
| Bad breath |  |  |  |
| Poor taste |  |  |  |
| Bleeding gums |  |  |  |
| Fillings |  |  |  |
| Root canals |  |  |  |
| Other |  |  |  |
| EYES |  |  |  |
| Gritty |  |  |  |
| Burning |  |  |  |
| Sticky/itchy |  |  |  |
| Dry |  |  |  |
| Blurred vision |  |  |  |
| Other |  |  |  |
| EARS |
| Blocked |  |  |  |
| Itchy |  |  |  |
| Ringing/Tinnitus |  |  |  |
| Other |  |  |  |
| NOSE |
| Blocked nose |  |  |  |
| Post nasal drip |  |  |  |
| Persistent sneezing |  |  |  |
| Nose bleeds  |  |  |  |
| Other |  |  |  |
| **ENERGY** |
| Tired all or some of the time |  |  |  |
| Need more than 8 hours sleep |  |  |  |
| Hard to get up |  |  |  |
| Too tired to exercise |  |  |  |
| Irritable/mood swings if miss a meal |  |  |  |
| Energy slumps |  |  |  |
| Other  |  |  |  |
| **MOOD** |
| Poor memory/concentration |  |  |  |
| General low mood |  |  |  |
| Occasional low mood |  |  |  |
| Anxiety |  |  |  |
| Impatient /intolerant |  |  |  |
| Other |  |  |  |
| **SKIN** |
| Eczema |  |  |  |
| Psoriasis |  |  |  |
| Acne |  |  |  |
| Dry |  |  |  |
| Oily |  |  |  |
| Puffy |  |  |  |
| Other |  |  |  |
| **IMMUNE** |
| Coughs/colds |  |  |  |
| Sinus |  |  |  |
| Asthma |  |  |  |
| Allergies: If yes please state below what you are allergic to. |  |  |  |
| **IMMUNE Continued**  |
| Other |  |  |  |
| **HEART/LUNGS** |
| High Blood Pressure |  |  |  |
| Low Blood Pressure |  |  |  |
| Poor circulation |  |  |  |
| Palpitations |  |  |  |
| Arrhythmias |  |  |  |
| Short of breath |  |  |  |
| Cough |  |  |  |
| Other  |  |  |  |
| JOINTS AND MUSCLES  |
| Please describe any joint or muscle issues you have below  |
|  |  |  |  |
| **DIGESTION** |
| Bloating |  |  |  |
| Wind  |  |  |  |
| Cramping |  |  |  |
| Constipation |  |  |  |
| Diarrhoea |  |  |  |
| Ulcers/Gastritis |  |  |  |
| Heartburn |  |  |  |
| Indigestion |  |  |  |
| Nausea |  |  |  |
| Pain |  |  |  |
| Diagnosed IBS |  |  |  |
| Diagnosed IBD |  |  |  |
| Hiatus Hernia  |  |  |  |
| Other  |  |  |  |
| FEMALE ONLY QUESTIONS  |
| What age did your periods start? |  |
| Are you periods regular |  |
| How many days is/was your normal cycle? |  |
| How is/was the flow? |  |
| Duration of bleeding |  |
| Mood before and during your period  |  |
| Breast tenderness |  |
| Endometriosis |  |
| Uterine fibroids |  |
| Excessive facial/body hair? |  |
| Low libido |  |
| Have you had fertility problems or fertility treatment? Please give details |  |
| Have you ever had a miscarriage? |  |
| Have you had pregnancy complications? Please give details |  |
| If menopausal, date of last period |  |
| Symptoms of menopause please describe |  |
| Other |  |
| MALE ONLY QUESITONS  |
| Prostate problems |  |
| Pain on urination |  |
| Frequent urination |  |
| Erectile dysfunction |  |
| Fertility issues  |  |
| Low libido  |  |
| Other  |  |

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| **PLEASE ADD ANYTHING ELSE NOT COVERED BY THE ABOVE QUESTIONS**  |
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| **NUTRITION and DIET**  |
| ***Please tick those boxes that relate to your present diet*** |
| Mixed food diet (*animal and vegetable sources*)  |  |
| Vegan (*No animal products*) |  |
| Lacto vegetarian (*No meat, fish, poultry or eggs but eats dairy*) |  |
| Lacto ovo vegetarian (*No meat, fish or poultry but eats dairy and eggs*) |  |
| Low salt |  |
| Low fat  |  |
| Low carbohydrate |  |
| Counting calories |  |
| Other; please describe  |  |
| **Please list any foods you exclude from you diet and why** |
|  |
| Have you taken any food allergy/intolerance tests? Please state type of test undertaken and results |
|  |
| How motivated are you to change the way you eat and to experiment with new foods?  |
| I am willing to try anything that might improve my wellbeing  |  |
| I feel I can make some changes  |  |
| I don’t really want to change anything |  |

**FOOD DIARY**

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| Please choose 2 fairly typical weekdays and a weekend (or day-off) and record. Please give as much information as possible: home cooked or not, brand names, fresh, packaged, whole, refined, organic, skimmed etc. and approximate quantities to help your Nutritional Therapist build an accurate picture of your diet and lifestyle. |
| **DAY 1** |
| **time** | **all food(s) eaten (*include snacks*) and drinks** ***e.g. Water, Coffee, Tea, Herbal tea, Juice, Fizzy, Alcohol etc*** | **approx. quantity** | **other information***e.g. Brands, Sugar or Salt Added* |
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| **DAY 2** |
| **time** | **all food(s) eaten (*include snacks*) and drinks** ***e.g. Water, Coffee, Tea, Herbal tea, Juice, Fizzy, Alcohol etc*** | **approx. quantity** | **other information***e.g. Brands, Sugar or Salt Added* |
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| **DAY 3** |
| **time** | **all food(s) eaten (*include snacks*) and drinks** ***e.g. Water, Coffee, Tea, Herbal tea Juice, Fizzy, Alcohol etc*** | **approx. quantity** | **other information***e.g. Brands, Sugar or Salt Added* |
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| ***IF YOU ARE UNDER 18 YOU WILL NEED CONSENT FROM A PARENT OR GUARDIAN TO SEE A NUTRITIONAL THERAPIST*** |
| **Name of Parent / Guardian:****Parent / Guardian Signature: ……………………………………………………. Date …………………** |

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| **Please return questionnaire within one week (at least a week prior to the conusltation ) to:** |
|  **Clinic Administrator****McClelland Centre, University of Worcester****Castle Street****WR1 3AS** nutritionaltherapyclinic**@worc.ac.uk****, 01905 54 2453** |