



INSTITUTE FOR OPTIMUM NUTRITION

Nutritional Therapy Questionnaire

Please provide details as fully and accurately as possible. If at any time you need more space, please continue on a separate sheet.

Title	First name	Last name	Date of birth	Age
Address				
Post code	E-mail	Phone numbers (H)	(M)	
Occupation		Work environment (eg city, farm)		

Health Profile

What is your main reason for seeking nutritional advice?

What outcome are you hoping to achieve?

Please list the health problems you would like to focus on. Continue on a separate sheet if you need more space

	Health Problem (e.g arthritis)	Management so far (eg GP, operation, exercise, medicine etc)	Onset (date)	Duration
1				
2				
3				
4				
5				

Have you had and recent health tests? Please specify or attach as appropriate?

Have you had any major surgery, biopsies, diagnosed medical conditions, significant periods of ill health, or do you suffer from any chronic or niggling health problems? Please give details (eg high blood pressure, frequent colds, recurrent urinary infections etc).

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

Medication & Remedies

Please list anything you take regularly including GP prescribed medication, self-prescribed medication (eg painkillers), nutritional supplements, herbal or homeopathic remedies. Continue on a separate sheet if necessary.

Remedy	Dose	Condition being treated	Frequency & Duration

Antibiotic history: please state when and why you last took antibiotics plus any previous times you can remember.

Body Scan

Please check the box alongside any condition that you regularly experience (ignore italics)

Head Headaches <input type="checkbox"/> Migraine <input type="checkbox"/> Stiff neck <input type="checkbox"/> Fuzzy headed <input type="checkbox"/> Dizziness <input type="checkbox"/> Poor balance <input type="checkbox"/> Pounding head <input type="checkbox"/> Feeling of hangover <input type="checkbox"/> Unexplained pain <input type="checkbox"/>	Ears Blocked <input type="checkbox"/> Sore <input type="checkbox"/> Itchy <input type="checkbox"/> Weeping <input type="checkbox"/> watery <input type="checkbox"/> Overly waxy <input type="checkbox"/> Creased earlobe <input type="checkbox"/>	Skin prone to Acne <input type="checkbox"/> Pimples <input type="checkbox"/> Rosacea <input type="checkbox"/> Eczema <input type="checkbox"/> Dermatitis <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rashes <input type="checkbox"/> Boils <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Stretch marks <input type="checkbox"/> Cellulite <input type="checkbox"/> Easy bruising <input type="checkbox"/> Thread veins <input type="checkbox"/> Varicose veins <input type="checkbox"/> Ringworm <input type="checkbox"/> Allergic reactions <input type="checkbox"/> Excessive sweating <input type="checkbox"/>	Chest Frequent colds and <input type="checkbox"/> Chest infections <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Diagnosed heart condition <input type="checkbox"/> Palpitations <input type="checkbox"/> Chest discomfort/pain <input type="checkbox"/> Short of breath <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Noisy breathing <input type="checkbox"/>	Mood (please tick boxes for predominant states - even if they conflict) Depressed <input type="checkbox"/> Anxious <input type="checkbox"/> Tense <input type="checkbox"/> Angry <input type="checkbox"/> Happy <input type="checkbox"/> Balanced <input type="checkbox"/> Optimistic <input type="checkbox"/> Sad <input type="checkbox"/> Pessimistic <input type="checkbox"/> Tired <input type="checkbox"/> Can't be bothered <input type="checkbox"/> Hyperactive <input type="checkbox"/> Cheerful <input type="checkbox"/> Agitated <input type="checkbox"/> Easily upset <input type="checkbox"/> Tearful <input type="checkbox"/> Jittery <input type="checkbox"/> Frightened <input type="checkbox"/> Explosive <input type="checkbox"/> Pent up <input type="checkbox"/> Worried <input type="checkbox"/> Annoyed <input type="checkbox"/> Overwhelmed <input type="checkbox"/> Suicidal <input type="checkbox"/> Fluctuating <input type="checkbox"/> Aggressive <input type="checkbox"/>
Hair Oily <input type="checkbox"/> Dry <input type="checkbox"/> Poor condition <input type="checkbox"/> Brittle <input type="checkbox"/> Thinning <input type="checkbox"/> Prematurely grey <input type="checkbox"/> Dandruff <input type="checkbox"/> Increased facial hair <input type="checkbox"/> Increased body hair <input type="checkbox"/> Deceased body hair <input type="checkbox"/>	Nose Stuffy <input type="checkbox"/> Congested <input type="checkbox"/> Runny <input type="checkbox"/> Frequent nose bleeds <input type="checkbox"/> Prone to snoring <input type="checkbox"/> Sinusitis <input type="checkbox"/> Hay fever <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Rhinitis <input type="checkbox"/> Sneezing <input type="checkbox"/> Poor sense of smell <input type="checkbox"/>	Joint (fingers, knees, back, shoulders etc) Painful <input type="checkbox"/> Inflamed <input type="checkbox"/> Swollen <input type="checkbox"/> Stiff <input type="checkbox"/> Rheumatic <input type="checkbox"/> Arthritic <input type="checkbox"/> Aching <input type="checkbox"/> Sore <input type="checkbox"/> Difficulty bending <input type="checkbox"/> Reduced mobility <input type="checkbox"/> Unsteadiness <input type="checkbox"/> Slow movement <input type="checkbox"/>	Gut Bloating <input type="checkbox"/> Tender <input type="checkbox"/> Cramping <input type="checkbox"/> Distended <input type="checkbox"/> Nausea <input type="checkbox"/> Sensation of fullness <input type="checkbox"/> Acid reflex <input type="checkbox"/> Heartburn <input type="checkbox"/> Flatulence <input type="checkbox"/> Belching <input type="checkbox"/> Churning <input type="checkbox"/> Painful <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Coeliac <input type="checkbox"/> Hiatus hernia <input type="checkbox"/> Diverticula <input type="checkbox"/> Polyps <input type="checkbox"/> Haemorrhoids <input type="checkbox"/> Ulcers <input type="checkbox"/> Sluggish <input type="checkbox"/> Sensitive <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhoea <input type="checkbox"/>	Mind Forgetful <input type="checkbox"/> Difficulty learning new things <input type="checkbox"/> Easily confused <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Easily frustrated <input type="checkbox"/> Easily distracted <input type="checkbox"/> Difficult to make decisions <input type="checkbox"/> Can't switch off <input type="checkbox"/> Loss of interest in daily life <input type="checkbox"/> Fogginess <input type="checkbox"/> Dyslexia <input type="checkbox"/> Dyspraxia <input type="checkbox"/> Hyperactive <input type="checkbox"/> Panic attacks <input type="checkbox"/> No motivation <input type="checkbox"/>
Mouth Sore tongue <input type="checkbox"/> Tooth decay <input type="checkbox"/> Mouth ulcers <input type="checkbox"/> Bad breath <input type="checkbox"/> Sore throats <input type="checkbox"/> Poor sense of taste <input type="checkbox"/> Excess saliva <input type="checkbox"/> Dry mouth <input type="checkbox"/> Difficult swallowing <input type="checkbox"/> Hoarse voice <input type="checkbox"/> Gingivitis <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Cold sores <input type="checkbox"/>	Muscles Tender <input type="checkbox"/> Sore <input type="checkbox"/> Cramps <input type="checkbox"/> Spasm <input type="checkbox"/> Twitches <input type="checkbox"/> Loss of tone <input type="checkbox"/> Wasting <input type="checkbox"/> Weak <input type="checkbox"/> Stiff <input type="checkbox"/> Frozen <input type="checkbox"/> 'Restless legs' <input type="checkbox"/> Numbness <input type="checkbox"/>	Nails Fragile <input type="checkbox"/> Dry <input type="checkbox"/> Brittle <input type="checkbox"/> Flaky <input type="checkbox"/> Peeling <input type="checkbox"/> Splitting <input type="checkbox"/> Split cuticles <input type="checkbox"/> Ridged <input type="checkbox"/> Spoon shaped <input type="checkbox"/> White spots on 2 or more nails <input type="checkbox"/> Horizontal white lines <input type="checkbox"/> Thickened or 'horny' <input type="checkbox"/> Dark nails <input type="checkbox"/> Pale nail bed <input type="checkbox"/> Infected <input type="checkbox"/>	Hands Dry <input type="checkbox"/> Cracked <input type="checkbox"/> Eczema <input type="checkbox"/> Sore joints <input type="checkbox"/> Puffy <input type="checkbox"/> Cold <input type="checkbox"/> Chilblains <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Feel clumsy & uncoordinated <input type="checkbox"/> Poor circulation <input type="checkbox"/>	Genitals Itchy <input type="checkbox"/> Cystitis <input type="checkbox"/> Thrush <input type="checkbox"/> Ulcers <input type="checkbox"/> Warts <input type="checkbox"/> Painful or frequent urination <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Herpes <input type="checkbox"/> Prostatitis <input type="checkbox"/> Groin pain <input type="checkbox"/> Impotence <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Unexplained discharge <input type="checkbox"/>
Eyes Burning <input type="checkbox"/> Gritty <input type="checkbox"/> Protruding <input type="checkbox"/> Prone to infection <input type="checkbox"/> Sticky <input type="checkbox"/> Itchy <input type="checkbox"/> Painful <input type="checkbox"/> Poor night vision <input type="checkbox"/> Dry <input type="checkbox"/> Cataracts <input type="checkbox"/> Sensitive to light <input type="checkbox"/> Bags <input type="checkbox"/> Swollen eyelids <input type="checkbox"/> Blurred vision <input type="checkbox"/> Double vision <input type="checkbox"/> Failing eyesight <input type="checkbox"/> Yellowish <input type="checkbox"/>	Skin Dry <input type="checkbox"/> Rough <input type="checkbox"/> Flaky <input type="checkbox"/> Sacky <input type="checkbox"/> Puffy <input type="checkbox"/> Pale <input type="checkbox"/> Brown patches <input type="checkbox"/> Change in moles or lesions <input type="checkbox"/> Prematurely lined <input type="checkbox"/> Congested <input type="checkbox"/> Oily <input type="checkbox"/> Clammy <input type="checkbox"/> Yellow <input type="checkbox"/>	Legs & feet Tender heels <input type="checkbox"/> Gout <input type="checkbox"/> Sciatica <input type="checkbox"/> Cold feet <input type="checkbox"/> Tingling <input type="checkbox"/> Numb <input type="checkbox"/> Prickling <input type="checkbox"/> 'Restless legs' <input type="checkbox"/> Swollen <input type="checkbox"/> Aching <input type="checkbox"/> Athlete's foot <input type="checkbox"/> Fungal nails <input type="checkbox"/> Burning feet <input type="checkbox"/>	Genitals Itchy <input type="checkbox"/> Cystitis <input type="checkbox"/> Thrush <input type="checkbox"/> Ulcers <input type="checkbox"/> Warts <input type="checkbox"/> Painful or frequent urination <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/>	Herpes <input type="checkbox"/> Prostatitis <input type="checkbox"/> Groin pain <input type="checkbox"/> Impotence <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal dryness <input type="checkbox"/> Unexplained discharge <input type="checkbox"/>

Important symptoms:
 Please check the box if you suffer from any of the following symptoms which may require additional medical care

Persistent or unexplained pain <input type="checkbox"/>	Unexplained bleeding or discharge from nipple, vagina or rectum <input type="checkbox"/>
Blood in sputum, vomit, urine or stools <input type="checkbox"/>	Breast lumps <input type="checkbox"/>
Inability to gain or lose weight <input type="checkbox"/>	Increased urination <input type="checkbox"/>
Painless ulcers or fissures <input type="checkbox"/>	Black tarry stools <input type="checkbox"/>
Bleeding in pregnancy <input type="checkbox"/>	Excessive thirst <input type="checkbox"/>
	Calf swelling <input type="checkbox"/>
	Unexplained bruising <input type="checkbox"/>
	Paralysis <input type="checkbox"/>
	Slurred speech <input type="checkbox"/>
	Difficulty swallowing <input type="checkbox"/>
	Loss of appetite <input type="checkbox"/>
	Rash or weight loss <input type="checkbox"/>

Your vital statistics

<input type="checkbox"/>	What is your normal blood pressure?
<input type="checkbox"/>	Your resting pulse rate?
<input type="checkbox"/>	Your current weight?
<input type="checkbox"/>	Your height?
<input type="checkbox"/>	Your waist circumference (cms) (if known)?
<input type="checkbox"/>	Your hip circumference (cms) (if known)?
<input type="checkbox"/>	Your blood type (if known)?
<input type="checkbox"/>	Is weight stable; increasing or decreasing?
<input type="checkbox"/>	Did you have the normal immunisations as a child?

Your family history

Do you have a family history of disease or allergies (e.g heart disease, diabetes, asthma, etc.)? State disease, age at onset, gender.

Grandparents:
Parents:
Siblings:
Children:

Your daily life

<input type="checkbox"/>	Do you enjoy your daily life?
<input type="checkbox"/>	How many people depend on your support?
<input type="checkbox"/>	Do you feel supported by the people around you?
<input type="checkbox"/>	Are you recently separated/divorced/a new parent?
<input type="checkbox"/>	Are you recently bereaved?
<input type="checkbox"/>	Have you moved house or changed jobs recently?
<input type="checkbox"/>	Do you work long or irregular hours?
<input type="checkbox"/>	Is your workload bigger than you can manage?
<input type="checkbox"/>	Are you significant stress in any other way; if so in what way?
<input type="checkbox"/>	Do you feel guilty when you are relaxing?
<input type="checkbox"/>	Do you have strong drive for achievement?
<input type="checkbox"/>	Do you often do 2 or 3 tasks simultaneously?
<input type="checkbox"/>	Do you take regular exercise?
<input type="checkbox"/>	Is your job active?
<input type="checkbox"/>	Do you have any active hobbies: if so what are they?
<input type="checkbox"/>	Do you sleep well?
<input type="checkbox"/>	What do you do for relaxation?

Your digestion

Do you regularly experience.....

<input type="checkbox"/>	Indigestion (after food or in between meals)?
<input type="checkbox"/>	Indigestions after fatty food?
<input type="checkbox"/>	Bowel movement shortly after eating?
<input type="checkbox"/>	Frequent stomach upsets or stomach pain?
<input type="checkbox"/>	Nausea or vomiting?
<input type="checkbox"/>	Pain between the shoulders or under the ribs?
<input type="checkbox"/>	Constipation or hard-to-pass stools?
<input type="checkbox"/>	Diarrhoea or 'urgency to go'?
<input type="checkbox"/>	Blood or mucus in stools?
<input type="checkbox"/>	Undigested food in stools?
<input type="checkbox"/>	Generally inconsistent bowel movements?
<input type="checkbox"/>	Anal itching?
<input type="checkbox"/>	Thrush or cystitis?
<input type="checkbox"/>	How many bowel movements do you have in 24 hours?
<input type="checkbox"/>	Have you noticed any recent change in bowel habit?
<input type="checkbox"/>	Are your stools pale, mid brown, dark brown, black, grey?
<input type="checkbox"/>	Have you ever had a stomach upset after foreign travel?
<input type="checkbox"/>	Do any foods cause digestive problems; if so which ones?

Your toxic exposure

<input type="checkbox"/>	Do you live, exercise or work in a city or by a busy road?
<input type="checkbox"/>	Do you spend a lot of time on busy roads?
<input type="checkbox"/>	Do you live close to an agricultural area?
<input type="checkbox"/>	Do you drink unfiltered water?
<input type="checkbox"/>	Do you drink alcohol; if so how many units per week?
<input type="checkbox"/>	What is your normal alcoholic drink?
<input type="checkbox"/>	Do you smoke: if so how many a day?
<input type="checkbox"/>	Do you live in a smoky atmosphere?
<input type="checkbox"/>	Do you think you might be addicted to anything; if so what?
<input type="checkbox"/>	Do you spend a lot of time in front of a TV or DVD?
<input type="checkbox"/>	Do you spend a lot of time on a mobile phone?
<input type="checkbox"/>	Do you sunbathe a lot?
<input type="checkbox"/>	Are you a frequent flyer?
<input type="checkbox"/>	Are you exposed to chemicals through work or hobby; if so which ones?
<input type="checkbox"/>	Do you heat, freeze or wrap food in plastics?
<input type="checkbox"/>	Do you cook or wrap food in aluminium?
<input type="checkbox"/>	Do you regularly take antacid (indigestion) medication?
<input type="checkbox"/>	Roughly what percentage of your food is organic?
<input type="checkbox"/>	Do you frequently fry or roast food at high temperatures?
<input type="checkbox"/>	Do you regularly eat browned or barbecued food?
<input type="checkbox"/>	Do you eat oily fish or shellfish more than 3 times a week?
<input type="checkbox"/>	Do you regularly consume artificial sweeteners?
<input type="checkbox"/>	Do you floss your teeth regularly?
<input type="checkbox"/>	Are your teeth filled with mercury amalgams?

Your energy levels

<input type="checkbox"/>	Do you need more than 8 hours sleep per night?
<input type="checkbox"/>	Is your energy less than you want it to be?
<input type="checkbox"/>	Do you find it difficult to get going in the morning?
<input type="checkbox"/>	Do you feel drowsy during the day?
<input type="checkbox"/>	What time(s) of day is your energy the lowest?
<input type="checkbox"/>	Do you get dizzy or irritable if you do not eat often?
<input type="checkbox"/>	Do you use caffeine, sugar or nicotine to keep going?
<input type="checkbox"/>	Do you find it difficult to concentrate?
<input type="checkbox"/>	Do you feel dizzy or light-headed if you stand up quickly?
<input type="checkbox"/>	Do you suffer from unexplained fatigue or listlessness?

Women Only

<input type="checkbox"/>	Are you pregnant; if so how many weeks?
<input type="checkbox"/>	Are you trying to become pregnant?
<input type="checkbox"/>	Are you breast-feeding at the moment?
<input type="checkbox"/>	How many children have you had?
<input type="checkbox"/>	Have you had problems with fertility?
<input type="checkbox"/>	Have you ever had a miscarriage?
<input type="checkbox"/>	What contraception you use?
<input type="checkbox"/>	Are you still menstruating?
<input type="checkbox"/>	Are you or have you been on HRT?
<input type="checkbox"/>	Are your periods regular?
<input type="checkbox"/>	Any bleeding or spotting in between?
<input type="checkbox"/>	Are your periods particularly heavy or painful?
<input type="checkbox"/>	Do you suffer from PCOS, fibroids or endometriosis?
<input type="checkbox"/>	Any known genito-urinary conditions?
<input type="checkbox"/>	Are you happy with your sex drive?

Menstruating women

Menopausal women

Please check the box if you experience

<input type="checkbox"/>	Pre-menstrual bloating	<input type="checkbox"/>	Hot flushes	<input type="checkbox"/>
<input type="checkbox"/>	Tiredness	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
<input type="checkbox"/>	Irritability	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>
<input type="checkbox"/>	Breast tenderness	<input type="checkbox"/>	Depression	<input type="checkbox"/>
<input type="checkbox"/>	Water retention	<input type="checkbox"/>	Vaginal dryness	<input type="checkbox"/>
<input type="checkbox"/>	Headaches	<input type="checkbox"/>		
Other?				

Men Only

<input type="checkbox"/>	Do you experience mood swings or depression?
<input type="checkbox"/>	Loss of sex drive?
<input type="checkbox"/>	Loss of motivation and drive?
<input type="checkbox"/>	Any known genito-urinary problems?
<input type="checkbox"/>	Fertility problems?
<input type="checkbox"/>	Problems achieving or maintaining an erection?
<input type="checkbox"/>	Frequent or difficult urination?
<input type="checkbox"/>	Prostate problems?
<input type="checkbox"/>	Wake at night to urinate?
<input type="checkbox"/>	Difficult to start or stop urine stream?
<input type="checkbox"/>	Pain or burning when urinating?

Eating habits

<input type="checkbox"/>	Which are your favourite foods?
<input type="checkbox"/>	Which foods do you dislike?
<input type="checkbox"/>	Which foods do you crave?
<input type="checkbox"/>	Which foods would you find it hard to give up?

<input type="checkbox"/>	Do you cater for a special diet in the household?
<input type="checkbox"/>	Who does the cooking in the household?
<input type="checkbox"/>	Do you avoid any foods for cultural/ethical reasons?
<input type="checkbox"/>	Do you suspect any foods don't agree with you?
<input type="checkbox"/>	Have you changed your diet recently?
<input type="checkbox"/>	Do you eat on the move/when stressed?
<input type="checkbox"/>	Do you ever have eating binges?
<input type="checkbox"/>	What do you binge on?
<input type="checkbox"/>	Have you ever suffered from an eating disorder?
<input type="checkbox"/>	Do you chew your food thoroughly?
<input type="checkbox"/>	Are you excessively thirsty?

Please complete the separate food and lifestyle diary

Health Care Providers

<input type="checkbox"/>	Is this your first visit to a Nutritional Therapist?
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<input type="checkbox"/>	How did you find out about me?
<input type="checkbox"/>	GP's Name Address
<input type="checkbox"/>	Phone

Are there any other therapists/clinics involved in your care? Please list

<input type="checkbox"/>	
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I have disclosed all the relevant information applicable to this consultation and my health status at this point in time. I consent for the information provided to be used by my Nutritional Therapist and for my therapist to liaise with appropriate health professionals.

<input type="checkbox"/>	Signed	<input type="checkbox"/>	Date
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3 Day Lifestyle Diary

Name

Date

Please choose 2 fairly typical weekdays and a weekend or 'day off' and record as much as can about your eating, sleep and leisure patterns on the page below. Please give as much information as possible – home cooked or not, brand names, fresh, packaged, whole, refined, organic etc. to help your nutritional therapist to build an accurate picture of your lifestyle.

Your Diet – please record your food intake across 2 work or week days and 1 weekend/day off.

	Weekday 1	Weekday 2	Day Off
Breakfast	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snacks	Time:	Time:	Time:
Drinks	coffees (sugars/cup)	coffees (sugars/cup)	coffees (sugars/cup)
	'normal' tea (sugars/cup)	'normal' tea (sugars/cup)	'normal' tea (sugars/cup)
	green/herbal tea	green/herbal tea	green/herbal tea
	fizzy drinks/cordial	fizzy drinks/cordial	fizzy drinks/cordial
	units of alcohol	units of alcohol	units of alcohol
	glasses of water	glasses of water	glasses of water
	other	other	other

Your routine – please do the same for your routine

	Day 1	Day 2	Day off
Wake up time			
Get up time			
Work day start time			
Work day breaks (total hrs)			
Work day end time			
Time spent travelling			
Time spent exercising			
Type or exercise			
Exercise time of day			
Time spent relaxing			
Type of relaxation			
Other leisure activity			
Other routine			
Energy low times			
Overall mood			
Go to bed time			
Fall asleep time			
Uninterrupted sleep?			