 Health and Nutritional

assessment

Questionnaire

Health should be natural to us... Avicenna

The part can never be well unless the whole is well. Plato

Treat the patient, not the disease, the cause, not the effect. Dr Edward Bach

The well-being of a man is influenced by all environmental factors, that quality of air, water and food... and the general living habits. Hippocrates

TITLE / FIRST NAME / SURNAME

HOME ADDRESS

TELEPHONE: HOME / MOBILE

EMAIL

DATE AND COUNTRY OF BIRTH

GP’S NAME AND PRACTICE ADDRESS

FAMILY SITUATION / MARITAL STATUS

YOUR CURRENT / FORMER OCCUPATION

EDUCATION

WHERE DID YOU FIND INFORMATION ABOUT THIS SERVICE

GOALS AND EXPECTATIONS

►YOUR EXPECTATIONS FROM THE CONSULTATION

►YOUR HEALTH GOALS AND MOTIVATION TO ACHIEVE THEM (OUT OF 10)

MEDICAL AND FAMILY HISTORY

►KNOWN OR SUSPECTED ALLERGIES / SENSITIVITIES (food, environmental, drug)

►YOUR MAIN HEALTH PROBLEMS/CONCERNS (Duration, how often, what brings about the symptoms, what brings relief, etc.)

►ANY OTHER HEALTH ISSUES OR FACTORS AFFECTING YOUR HEALTH

►YOUR CURRENT OR FREQUENTLY TAKEN MEDICATIONS AND/OR SUPPLEMENTS (Prescription, non-prescription, herbal, vitamins etc. Please, state the name, dosage, for how long you have been taking it and any side-effects.)

►WHAT LAB. TESTS / INVESTIGATIONS HAVE YOU HAD IN THE LAST YEAR? (Please, send or bring the copies of your test results, if possible.)

►IF YOU RECEIVE ANY COMPLEMENTARY THERAPY, WHAT TYPE AND REASON

►YOUR MEDICAL HISTORY (Conditions you were/are prone to, medical diagnoses, treatments, operations, admissions to hospital.)

Birth – 10 y.o

10 – 20 y.o

 20 – 30 y.o

30 – 40 y.o

40 – 50 y.o

50+

►YOUR FAMILY HISTORY (Illnesses your family are/were prone to, i.e.asthma, diabetes, stroke, migraine, skin problems, cancer, heart disease, epilepsy, blood disorders, mental problems, depression, alcoholism, liver, kidney problems, obesity, arthritis, etc. Please, if known, state the age when your relative developed a particular illness and the age and cause of death where appropriate.)

MOTHER

FATHER

GRANDPARENTS

YOUR SIBLING/S

YOUR CHILDREN

►WEIGH AND HEIGHT

► YOUR USUAL BLOOD PRESSURE (if known)

►BLOOD GROUP (if known)

►ARE YOU CURRENTLY PREGNANT? YES NO UNSURE

LIFESTYLE AND EATING PATTENRS

►PHYSICAL ACTIVITIES: HRS/WEEK, TIMES/WEEK AND TYPES

►IF YOU SMOKE: CIGARETTES PER DAY AND HOW LONG (YEARS).

►IF YOU DRINK ALCOHOL, AMOUNT PER WEEK AND PREFFERED TYPE/S

►IF YOU USE/D RECREATIONAL DRUGS, WHAT TYPE/S AND DURATION

►YOUR BED / WAKING UP TIME AND ANY SLEEP RELATED PROBLEMS

► DO YOU FEEL THAT YOU HAVE BEEN EXPERIENCING STRESS OVER THE LAST 5 YEARS occasionally / frequently/ continuously

► IN THE LAST 5 YEARS HAVE YOU EXPERIENCED: death of a close relative or close friend / divorce or separation / serious personal illness or injury / loss of a job / other

► MAIN KNOWN CAUSES OF STRESS

► YOUR TYPICAL REACTION TO STRESS

► YOUR STRESS CONTROL AND RELAXATION

► HOW WOULD YOU DESCRIBE YOUR APPETITE

► WHAT ARE YOUR COMFORT FOODS

► WHAT FOODS YOU CAN’T LIVE WITHOUT

►WHAT DO YOU RESTRICT / AVOID IN YOUR DIET AND THE REASONS FOR THAT

► WHAT TYPE OF WATER DO YOU DRINK MOSTLY (TAP, FILTERED, BOTTLED)

► WHERE DO YOU SHOP FOR FOOD

► HOW OFTEN DO YOU COOK YOUR MEALS

► HOW OFTEN DO YOU EAT OUT? WHAT ARE YOUR PREFERENCES?

|  |  |  |  |
| --- | --- | --- | --- |
| Difficulty getting up in the morning, slow starter, fatigue not relieved by sleep |  | Decreased ability to handle stress |  |
| Lack of energy / easily fatigued |  | Increased effort to do everyday tasks, less productive at work and home |  |
| Energy fluctuation during the day |  | Muscle weakness or cramps |  |
| Always tired / exhausted  |  | Decreased tolerance, irritated easily |  |
| Need sleep during the day |  | Less enjoyment, pleasure in life |  |
| Excessive dreaming or nightmares |  | Racing mind, thoughts less focused |  |
| Poor dream recall in the mornings |  | Light headed when standing uprapidly , blackouts or feeling dizzy  |  |
| Early morning waking up (3-5 am) or light interrupted sleep |  | Afternoon (2-5pm) yawning, tired, sleepy, headache, need a cup of tea |  |
| Teeth grinding  |  | Craving salty foods / snacks |  |
| Difficulty falling asleep |  | Second wave after 7-8 pm, feeling more active again |  |
| Sleep apnoea, snoring |  | Increased time to recover from stress, injury, cold, etc  |  |
| Night sweats |  | Unable to relax, switch off, tired but wired |  |
| Anger, fears, sadness, grief |  | Irritability or headaches or shakiness if meals are missed |  |
| Low self-esteem |  | Have to have tea, coffee or chocolate in the afternoon |  |
| Emotional, cry easily |  | Working long hours |  |
| Perfectionism |  | Steroid medications / history of it |  |
| Mood swings, feeling low often, SAD |  | Gaining weight around the middle  |  |
| Can’t work / function under pressureFeeling shaky, nervous |  | Mentally sluggish, reduced initiative |  |
| Less interest in sex |  | Declining memory, forgetful |  |
| Anxiety, worrying a lot  |  | Chronic Fatigue syndrome (ME)  |  |
| Panic attacks |  | History of glandular fever, shingles, herpes, other viral infections |  |
| Sensitive to bright light, sounds |  | Frequent headaches or migraines  |  |
| Osteoporosis / bone fractures / loss of height  |  | Sensitivities to dust, pollen, yeast, MSG, perfumes , chemicals, damp places, etc |  |
| Childhood or travel vaccination |  | Slow wound healing |  |
| Dry skin / hair |  | Psoriasis |  |
| Oily skin / hair |  | Increased / Decreased sweating |  |
| Acne currently or history of it |  | Ethnic dark skin |  |
| Eczema, sensitive skin |  | Hair loss or dandruff |  |
| Rashes, warts, skin lesions |  | Early grey hair |  |
| Tendency to bruise easily, nosebleeds  |  | Weak soft nails or white spots on nails |  |
| Strong body odours |  | Fungal skin or nail infections |  |
| Numbness, tingling in hands / feet |  | Dry / irritated eyes / blepharitis  |  |
| Gait or balance problems |  | Glaucoma / cataract / poor of vision / night blindness  |  |
| Unexplained weight loss / gain  |  | Frequent respiratory , ear, skin, kidney / bladder infections |  |
| Difficulty loosing or gaining weight |  | Multiple courses of antibiotics  |  |
| History of asthma, hives |  | Frequent colds / recurrent mouth ulcers |  |
| Frequent urination daytime or at night |  | History of dieting for weight loss |  |
| Decreased sense of taste / smell |  | Preference for cold foods or drinks |  |
| Vegetarian / vegan now or in the past / special diets |  | Preference for warm food or drinks |  |
| Eating mostly organic foods |  | Not washing vegetables/ fruits |  |
| Skipping breakfast |  | Vitamin tablets upset stomach |  |
| Often snacking versus cooked meals |  | Specific food/s make me tired / sleepy / bloated / spacey  |  |
| Eating in a rush or when stressed, not chewing foods well |  | Gall-bladder removed or stones |  |
| Feeling thirsty a lot |  | Dislike or intolerance of fatty/ oily foods |  |
| Amalgam fillings now or in the past, bleeding gums, gum disease, root canals |  | Easily intoxicated by alcohol, history of alcohol abuse |  |
| Bad taste in the mouth, sore tongue  |  | History of jaundice / hepatitis / Gilbert’s syndrome |  |
| Bad breath or coated tongue |  | History of anaemia |  |
| Difficulty swallowing foods, fluids or tablets |  | History of parasites, worms, Bacterial or viral bowel infection |  |
| Heartburn / indigestion / acid reflux / GERD / hiatus hernia |  | Alternating constipation and diarrhoea / urgency |  |
| Indigestion / acid blocking medication |  | Recent change in bowel habits |  |
| Belching after meals, bloated within 1 hour after a meal |  | Excessive wind / flatulence with strong smell |  |
| Excess fullness after a light meal |  | Abdominal pain relieved bybowel movements |  |
| Nausea after meals |  | Straining when moving bowels |  |
| Stomach ulcer or history of it |  | Feeling of incomplete emptying |  |
| Dislike for meat ( too heavy ) |  | Anal itching |  |
| H. pylori test positive or history of it |  | Haemorrhoids |  |
| Feeling bloated 1-2 hours after a meal |  | Blood in the stool or black stool |  |
| Abdominal cramps / pain |  | Tan or clay colour of the stool |  |
| Family history of bowel, celiac disease, IBS |  | Undigested foods in stool |  |
| Having sweet tooth or craving chocolate |  | Don’t feel well / get moody without starchy foods (rice, potatoes, bread) |  |
| Need to eat often (every 2-3 hrs) |  | History of anorexia / bulimia |  |

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|  If having periods, date of your last one  |  | Premenstrual breast tenderness, swelling |  |
| Low abdominal pain / cramps |  | PMS, mood swings related to periods |  |
| Recurrent thrush |  | Last period was 6 months ago or longer |  |
| Vaginal discharge or irritation |  | Postmenopausal bleeding |  |
| Vaginal dryness |  | Postmenopausal depression / hot flushes |  |
| Endometriosis |  | Hysterectomy  |  |
| Uterine fibroids |  | Breast lumps or history of it |  |
| Heavy periods / clots |  | Breast cancer or history of it |  |
| Very light periods |  | Abnormal cervical smear or history of it |  |
| Irregular periods |  | Hormonal contraception currently |  |
| Very painful periods, use of painkillers  |  | Use of hormonal pills for treatment of conditions |  |
| Excessive facial or body hair |  | HRT or history of it |  |
| Polycystic ovaries syndrome |  | Urinary incontinence |  |
| Ovarian cyst or tumour or history of it |  | Trying / planning to get pregnant  |  |
| Caesarean section/s |  | Infertility treatments currently or in the past, or difficulty getting pregnant |  |
| Uterine or bladder prolapse |  | Painful sex or avoidance |  |

►IS THERE ANYTHING ELSE YOU WANT ME TO KNOW IN CONNECTION WITH YOUR HEALTH?