



# the nutri centre

## Nutritional Therapy Consultation Form

Nutritionist's name:.....

Store location:.....

Date of consultation: .....

## Customer details

Name:	<input type="text"/>
Date of birth:	<input type="text"/>
Occupation:	<input type="text"/>
Height:	<input type="text"/>
Weight:	<input type="text"/>
Phone number:	<input type="text"/>
Email address:	<input type="text"/>
Address:	<input type="text"/>

Sex: M  F

## Only for women

Are you currently pregnant? Y  N   
Are you currently breastfeeding? Y  N

**Please provide details of any medications prescribed by your doctor / consultant that you are currently taking:**

**Please provide details of any nutritional supplements or herbal medicines that you are currently taking:**

What is the reason you are seeking nutritional support? Please only give a brief comment here as further information will be requested during your consultation.

## Medical history

Please fill in below any current and previous medical conditions, with treatment you have had for them.

Medical condition, disease or diagnosis	Date and duration	Treatment for this condition - please list all medication and operations you may have had	Do you have any current symptoms or problems related to this condition? If so please give details.
Example: Depression	2009-2011	Citalopram medication	None
Example: Hypertension	2006: 1 year	Ramipril medication	Better after a year



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## General health questions

### Family health

#### Smoking, alcohol and exercise

Do you smoke cigarettes? Yes  No

If so, how many per day?

How many per week?

Do you drink alcohol? Yes  No

If so, how many units (or pints/glasses)

per day or per week?

What type of alcohol do you most commonly drink?

Do you exercise or play sports? Please give details of the type of activity and number of hours per week.

#### Heart and cholesterol

Do you have any problems with your heart or blood pressure? If so, please give details.

Do you have high cholesterol? If so, please give your total cholesterol level if known.

## Digestive system / gastrointestinal

Do you suffer from any of the following gastrointestinal conditions? Please tick any that apply - you can tick more than one box.

<input type="checkbox"/> IBS (irritable bowel syndrome)	<input type="checkbox"/> Yeast overgrowth
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Hiatus hernia
<input type="checkbox"/> Heartburn	<input type="checkbox"/> Parasitic infection (worms etc.)
<input type="checkbox"/> Coeliac disease	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> Gluten intolerance / sensitivity	<input type="checkbox"/> Crohn's disease
<input type="checkbox"/> Lactose intolerance / sensitivity	<input type="checkbox"/> Acid reflux
<input type="checkbox"/> Constipation	<input type="checkbox"/> Any other condition not covered here?
<input type="checkbox"/> Diarrhoea	If so, please state which. <input type="text"/>

Do you suffer from any of the following gastrointestinal symptoms? Tick any that apply - you can tick more than one box.

<input type="checkbox"/> Flatulence (wind)	<input type="checkbox"/> Feeling like you cannot digest fatty meals easily
<input type="checkbox"/> Bloating	<input type="checkbox"/> Often feeling 'over-full' after meals
<input type="checkbox"/> Indigestion	<input type="checkbox"/> Itchy anus
<input type="checkbox"/> Constipation	
<input type="checkbox"/> Nausea after eating	

Any other symptom not covered here:

On average, how many bowel movements do you have per day?

Do you suffer from constipation?

Yes  No

Do you suffer from diarrhoea?

Yes  No

## Ears, nose and eyes

Do you currently have any of the following? Tick any that apply - you can tick more than one box.

<input type="checkbox"/> A reduction in taste or smell	<input type="checkbox"/> Recurrent eye infections
<input type="checkbox"/> Loss of balance (e.g. labyrinthitis, vertigo)	<input type="checkbox"/> Recurrent ear infections

## Kidneys and bladder

- Do you suffer from water retention? Yes  No
- Do you have any problems with urination (over-frequent urination, slow emptying bladder or leaking / incontinence)? Yes  No   
If so, please give brief details.
- Do you suffer from cystitis or interstitial cystitis? Yes  No   
If so, please specify which and give brief details.

## Immune system

- How many instances of colds or flu have you experienced in the last 12 months?
- How many instances of coughs / chest infections have you experienced in the last 12 months?
- Do you have any known problems with your immune system (e.g. an autoimmune condition)? Y  N   
If so, please briefly state the problem.
- Do you find you get over normal everyday illness quickly? Yes  No
- Do you have any issues with your throat (constant sore throats, loss of voice etc.)? Yes  No   
If so, please give brief details.
- Do you get cold sores regularly? Yes  No
- Have you ever had glandular fever? Yes  No
- Do you experience hay fever / seasonal allergies? Yes  No
- Do you or have you recently suffered from athlete's foot? Yes  No
- Have you ever suffered from adult shingles? Yes  No   
If so, is it recurring? Yes  No
- If you have a cut or graze, do you find it heals quickly? Yes  No
- Do you have any issues with your respiratory tract (lungs, breathing) such as asthma or constant infections? Yes  No   
If so, please give brief details.
- Do you experience a lot of mucus or find you have to clear your throat regularly? Yes  No
- Do you commonly experience bleeding gums? Yes  No
- How often have you had antibiotics in your life? Please tick the most appropriate number below.  
Less than twice  3 to 6 times  7 to 10 times  More than 10 times

## Nutrient status

- Are you suffering from anaemia or low iron levels, or are you currently taking iron supplements / medication to correct or prevent an iron deficiency? Yes  No   
If so, please give brief details.
- Have you had your vitamin B12 levels recently checked? Yes  No   
If so, what was the result?
- Have you had your vitamin D levels recently checked? Yes  No   
If so, what was the result?
- Have you had your calcium levels recently checked? Yes  No   
If so, what was the result?
- How much sun exposure do you get?   
Please give details if you work outside or have recently been on a sunny holiday where you had sunlight onto your skin.

## Weight

- Do you have any problems with your weight? Yes  No   
If so, please give brief details.
- Would you like help managing your weight? Yes  No

## Energy, sleep and stress

- Do you suffer from a thyroid condition or have any issues with your thyroid function? Yes  No   
If so, give brief details.
- Do you have any known issues with your adrenal function? Yes  No   
If so, give brief details.
- How would you rate your general energy level out of 10? (1 = very poor, 10 = excellent)
- Do you have any problems with your sleep? E.g. difficulty falling asleep, waking up and not being able to get back to sleep? Yes  No   
Please describe briefly.
- How would you rate your average stress levels, out of 10? (1 = not at all stressed, 10 = highly stressed)

## Blood sugar / cravings

- Do you crave carbohydrates, starchy foods or sweet foods? Yes  No   
Please give brief details.
- Do you feel you cannot go without food for very long, or experience any of these symptoms if you haven't eaten for a while: headaches, nausea, mood swings, weakness? Yes  No   
Please state which.

## Muscles, joints and bones

Do you have any physical pain (e.g. back pain, knee pain)? Yes  No   
If so, please indicate location(s) of the pain.

Do you have any of the following? Tick any that apply - you can tick more than one box.

<input type="checkbox"/> Osteopaenia	<input type="checkbox"/> Joint pain / stiffness
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Anything else relating to your muscles, joints or
<input type="checkbox"/> Arthritis	bones?

## Dietary questions

- Do you have any food allergies or intolerances? Yes  No   
Please give details if so.
- Do you avoid any foods for religious or ethical reasons? Yes  No   
If so, which foods?
- What foods do you dislike?
- What are your favourite foods?
- Do you have any food cravings? Yes  No   
If so, please indicate which foods you crave.
- What percentage of your meals are home-cooked / home-prepared? (approximately)
- Do you eat oily fish? Yes  No   
If so, how often?

## Mental well-being / memory and concentration

- Do you suffer from low moods or depression? Yes  No   
If so, give brief details.
- Do you suffer from SAD (seasonal affective disorder)? Yes  No
- Do you suffer from any other mental health disorders (e.g. obsessive compulsive disorder)? Yes  No   
If so, give brief details.
- Do you feel you have a good memory? Yes  No
- Do you feel you have good concentration? Yes  No
- Do you suffer from headaches or migraines? Yes  No   
If so, how often?

## Hair and skin

- Do you have any issues with your hair (e.g. dryness, hair loss, eyebrow loss)? Yes  No   
If so, give brief details.
- Do you have any issues with your skin health (e.g. dry skin, eczema, or other skin conditions)? Yes  No   
If so, give brief details.

## Men

- Do you have any problems with your prostate? Yes  No   
If so, give brief details.
- Do you have any known problems with fertility (e.g. low sperm count)? Yes  No   
If so, give brief details.
- Do you have any other issues relating to male health? Yes  No   
If so, give brief details.

Please add anything else you would like us to know about you which may be relevant.



## Women's health questions

Please complete this section even if you are (or you suspect you are) entering the menopause, as some of the questions are still relevant for this time. If you have completely menopausal, please fill in the peri-menopause and menopause section of this questionnaire, below.

- What form of contraception do you currently use (if any)?
- Do you currently have periods?  Yes  No  
If no, give a reason (if you don't know, put 'not known').
- Are you currently taking any prescription hormone medication such as HRT or progesterone?  Yes  No  
If so, give details.
- Are you currently trying for a baby?  Yes  No  
If so, give details if you have been experiencing any difficulties in conceiving (including any miscarriages or ectopic pregnancies).
- If you have had any children, please give their ages.
- What is the average length of your cycle (e.g. 24 days)?  days
- Do you experience irregular periods?  Yes  No  
If so, give brief details.
- Do you suffer from endometriosis?  Yes  No  
If so, give brief details.
- Do you suffer from fibroids?  Yes  No  
If so, give brief details.
- Do you suffer from polycystic ovary syndrome?  Yes  No  
If so, give brief details.
- Do you experience heavy bleeding?  Yes  No  
If so, give brief details.
- Do you experience painful periods?  Yes  No  
If so, give brief details.
- Do you experience vaginal thrush?  Yes  No  
If so, give brief details.
- Do you feel you have low libido?  Yes  No

## Perimenopausal and menopausal women health questions

Please complete this section if you are going through the menopause, or are experiencing symptoms of menopause either before or after your periods have stopped.

- When was your last period? Give details in days, months or years.

Yes  No

- Are you taking HRT or similar?

- Have you been using (or have used) any specific supplements to help you with the menopause e.g. black cohosh, sage?

Yes  No

If so, which?

If you are going through the menopause (or believe you may be) please tick if you are experiencing any of these symptoms. Tick all the boxes that are applicable.

- Hot flushes or feeling too warm
- Cold chills
- Increase in blood pressure (high blood pressure)
- Tiredness / fatigue
- Brain fog / poor concentration
- Forgetfulness (poor memory)
- Feeling more irritable or angry
- Weight gain (all over body)
- Weight gain only around the abdomen
- Dry skin

- Dry vagina
- Decreased libido
- Problems with urination (small amounts of urine leaking)
- Urinary incontinence
- Hair loss on your eyebrows
- Difficulty in falling asleep
- Loss of sleep or waking at night
- Problems with your thyroid
- Thinning hair or hair loss (on head)

Please use this box if you want to give any further information about your peri-menopause or menopause experience or symptoms.

Here is a list of common pre-menstrual complaints (before your period starts).

Tick any that apply - you can tick more than one box.

- Feeling tearful / emotional
- Mood swings / getting easily annoyed or frustrated
- Feeling especially tired
- Tender breasts
- Backache

- Headaches or migraines
- Bloating or feeling as though you have gained weight
- Food cravings / increased appetite
- Low moods

Any other symptoms:

Here is a list of common menstrual complaints (during the days of your actual period).

Tick any that apply - you can tick more than one box.

- Cramping or pain
- Nausea
- Feeling especially tired
- Headaches or migraines

- Heavy bleeding just on first or second day
- Heavy bleeding for the first three to four days
- Backache

Any other symptoms:

Please use this box if you want to give any further information about your female health and menstrual cycle.



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## Instructions on how to complete your Food Diary

### What do I need to put in my food diary?



- Write down everything that you eat and drink, including all meals and snacks over the days that you are filling in the diary.
- Please state whether meals are home-made, a ready-meal, a takeaway or a restaurant meal.
- Do not be afraid to be honest. For example, if you ate three chocolate bars in one day or drank three cans of cola, please note that down. We are not here to judge, only help.
- Please be specific about quantities, if possible. For example, say “6 Brazil nuts” as opposed to just “Brazil nuts”. Or “1 chicken breast” as opposed to “chicken breast”.
- Be specific rather than generic about the types of foods you list. So if you ate fruit, please say what type, e.g. “2 apples” or “1 banana”. Please do not just put down “fruit”.
- If you have coffee or tea, please note if it is ‘normal’ or decaffeinated. If you are drinking coffee in a café, restaurant etc. please indicate what type of coffee, e.g. “espresso”, “latte with full-fat milk”. If you have herbal tea, green tea or other types of tea, please indicate which.
- If you use sugar or other similar sweeteners, please note which and how much, e.g. “2 teaspoons of honey”, or “1 teaspoon of white sugar”.
- If you drink water, please note how much in number of glasses or litres, and include details such as ‘still’ or ‘sparkling’.

Date:

**DAY 1**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 2**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 3**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 4**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 5**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 7**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

**DAY 7**

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration