NOONIE ZAND GOODARZI NUTRITION
Nutritional Therapy Questionnaire

Please provide details as fully and accurately as possible, continuing on a separate sheet if necessary.

Name

Date of Birth | Age

Address

Postcode | Email

Phone number | Occupation

Work environment (e.g. city, farm etc)

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.

Health Problem (e.g. arthritis)	Management so far (e.g. GP, operation, exercise, paracetamol etc.)	Onset (date)	Duration

Have you had any recent health tests? Please specify or attach, if appropriate.

Have you had any other 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 e.g. 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 (e.g. painkillers) nutritional supplements, herbal or homeopathic remedies. Continue on a separate sheet if necessary.

Remedy	Dose	Condition being treated	Frequency and duration

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

Body Scan

Please select any conditions that you regularly experience by highlighting.

Head
headaches, migraine, stiff neck, fuzzy headed, dizziness, poor balance, pounding head, feeling of hangover, unexplained pain

Hair
oily, dry, poor condition, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decreased body hair

Mouth
sore tongue, tooth decay, mouth ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, difficult swallowing, hoarse voice, gingivitis, bleeding gums, cold sores

Eyes
burning, gritty, protruding, prone to infection, sticky, itchy, painful, poor night vision, dry, cataracts, sensitive to light, bags, swollen eyelids, blurred vision, double vision, failing eyesight, yellowish

Ears
blocked, sore, itchy, weeping, watery, overly waxy, creased earlobe

Nose
stuffy, congested, runny, frequent nose bleeds, prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

Skin
dry, rough, flaky, scaly, puffy, pale, brown patches, change in moles or lesions, prematurely lined, congested, oily, clammy, yellow

Skin prone to
acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

Joints (fingers, knees, back, shoulders etc.)
painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

Legs & Feet
restless legs, swollen, aching, athlete's foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, numb, prickling

Mood
(please insert your predominant states - even if they conflict)
depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, annoyed, overwhelmed, suicidal, fluctuating, aggressive

Mind
forgetful, difficulty learning new things, easily confused, difficult concentrating, easily frustrated, easily distracted, difficult to make decisions, can't switch off, loss of interest in daily life, fogginess, dyslexia, dyspraxia, hyperactive, panic attacks, no motivation

Muscles
tender, sore, cramps, spasms, twitches, loss of tone, wasting, weak, stiff, frozen, 'restless legs', numbness

Chest
frequent colds and chest infections, asthma, bronchitis, diagnosed heart condition, palpitations, chest discomfort/pain, short of breath, difficulty breathing, wheezing, persistent cough, noisy breathing

Gut
bloated, tender, cramping, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, painful, Irritable bowel syndrome, coeliac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, constipation, diarrhoea

Genitals
itchiness, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, painful or frequent urination, unexplained discharge

Hands
dry, cracked, eczema, sore joints, puffy, cold, chilblains, numbness, tingling, feel clumsy & uncoordinated, poor circulation

Nails
fragile, dry, brittle, flaky, peeling, splitting, hangnails (split cuticles), ridged, spoon shaped, white spots on more than 2 nails, horizontal white lines, thickened or 'horny, dark nails, pale nail bed, infected

Important symptoms:

Please indicate by underlining if you suffer from any of the following symptoms which may require additional medical care: persistent or unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine, stools; breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash or weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy.

Your vital statistics

What is your normal blood pressure?

your resting pulse rate?

your current weight?

your height ?

your waist circumference? (if known)

your hip circumference? (if known)

your blood type? (if known)

Is your weight stable, increasing or decreasing?

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

Do you enjoy your daily life?

How many people depend on your support?

Do you feel supported by people around you?

Are you recently separated/divorced/a new parent?

Are you recently bereaved?

Have you moved house or changed jobs recently?

Do you work long or irregular hours?

Is your workload bigger than you can manage?

Are you under significant stress in any other way?

Do you feel guilty when you are relaxing?

Do you have a strong drive for achievement?

Do you often do 2 or 3 tasks simultaneously?

Do you take regular exercise?

Is your job active?

Do you have any active hobbies?

Do you sleep well?

What do you do for relaxation?

Your digestion

Do you regularly experience:

Indigestion (after food or between meals?)

Indigestion after fatty food?

Bowel movement shortly after eating?

Frequent stomach upsets or stomach pain?

Nausea or vomiting?

Pain between the shoulders or under the ribs?

Constipation or hard-to-pass stools?

Diarrhoea or 'urgency to go'?

Blood or mucus in stools?

Undigested food in stools?

Generally inconsistent bowel movements?

Anal itching?

Thrush or cystitis?

How many bowel movements do you have in 24 hours?

Have you noticed any recent change in bowel habit?

Are your stools pale, mid brown, dark brown, black, grey?

Have you ever had a stomach upset after foreign travel?

Do any foods cause digestive problems? (which ones?)

Your toxic exposure

Do you live, exercise or work in a city or by a busy road?

Do you spend a lot of time on busy roads?

Do you live close to an agricultural area?

Do you drink unfiltered water?

Do you drink alcohol? If so, how many units a week?

What is your normal alcoholic drink?

Do you smoke? If so, how many a day?

Do you live in a smoky atmosphere?

Do you think you may be addicted to anything?

Do you spend a lot of time in front of a TV or VDU?

Do you spend a lot of time on a mobile phone?

Do you sunbathe a lot?

Are you a frequent flier?

Are you exposed to chemicals through work or hobby?

Do you heat, freeze or wrap food in plastics?

Do you cook or wrap food in aluminium?

Do you regularly take antacid (indigestion) medication?

Roughly what percentage of your food is organic?

Do you frequently fry or roast food at high temperatures?

Do you regularly eat browned or barbecued foods?

Do you eat oily fish or shellfish more than 3 x a week?

Do you regularly consume artificial sweeteners?

Do you floss your teeth regularly?

Are your teeth filled with mercury amalgams?

Your energy levels

Do you need more than 8 hours sleep per night?

Is your energy less than you want it to be?

Do you find it difficult to get going in the morning?

Do you feel drowsy during the day?

What time(s) of day is your energy lowest?

Do you get dizzy or irritable if you don't eat often?

Do you use caffeine, sugar or nicotine to keep going?

Do you find it difficult to concentrate?

Do you feel dizzy or light-headed if you stand up quickly

Do you suffer from unexplained fatigue or listlessness?

Eating Habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you fi nd hard to give up?

Do you cater for a special diet in the household?

Who does the cooking in your household?

Do you avoid any food for cultural/ethical reasons?

Do you suspect any foods don't agree with you?

Have you recently changed your diet?

Do you eat on the move/when stressed?

Do you ever have eating binges?

What do you binge on?

Have you ever suffered from an eating disorder?

Do you chew your food thoroughly?

Are you excessively thirsty?

Please complete the separate food and lifestyle diary on the LAST 2 PAGES

Women Only

Are you pregnant? If so, how many weeks?

Are you trying to become pregnant?

Are you breast-feeding at present?

How many children have you had?

Have you had problems with fertility?

Have you ever had a miscarriage?

What contraception do you use?

Are you still menstruating?

Are you or have you been on HRT?

Are your periods regular?

Any bleeding or spotting in between?

Are your periods particularly heavy or painful?

Do you suffer from PCOS, fibroids, endometriosis?

Any known genito-urinary conditions?

Are you happy with your sex drive?

Menstruating Women: please indicate if you experience:
pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches. Other?

Menopausal Women: please indicate if you suffer from:
hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

Men Only

Do you experience mood swings or depression?

Loss of sex drive?

Loss of motivation and drive?

Any known genito-urinary conditions?

Fertility problems?

Problems achieving or maintaining an erection?

Frequent or diffi cult urination?

Prostate problems?

Wake at night to urinate?

Difficult to start or stop urine stream?

Pain or burning when urinating?

Health Care Providers

Is this your first visit to a Nutritional Therapist?

How did you find out about me?

GP's Name:

Phone:

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

I have disclosed all the relevant information applicable to this consultationand 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.

Signed

Date

3 Day Lifestyle Diary

Please choose 2 fairly typical weekdays and a weekend or 'day off' and record as much as you 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.

Name **Date**

YOUR DIET	**Day 1**	**Day 2**	**Day 3**
Breakfast **Time:**			
Lunch **Time:**			
Dinner **Time:**			
Snacks **Time:**			
Drinks **Time:**	Coffees (___ sugars/cup) Tea (___ sugars per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks	Coffees (___ sugars/cup) Tea (___ sugars per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks	Coffees (___ sugars/cup) Tea (___ sugars per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks.....

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 of 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?	☐ YES / NO ☐	☐ YES / NO ☐	☐ YES / NO ☐