missionnutrition

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

Postcode | E-mail | Phone numbers

Occupation | Work environment (e.g. city, farm, office)

Health profile

What is your main reason for seeking nutritional advice?

What outcome are you hoping to achieve?

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

Health issue (e.g. arthritis, overweight)	Management so far (e.g. GP, operation, exercise, paracetamol, etc.)	Onset/Duration
1		
2		
3		
4		
5		

Have you had any recent health tests? *Please supply results if appropriate.*

Have you had any other major surgery, biopsies, diagnosed medical conditions, significant periods of ill health or do you suffer from any allergies, 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 & duration
Antibiotic history: please state when and why you last took antibiotics plus any previous times you can remember:			

Body Scan

Please click any conditions that you regularly experience

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, white/red patches, tooth decay, 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*, failing eyesight, yellowish

Ears

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

Nose

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

Muscles

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

Skin

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

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

Mood

(please click 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, irritated, annoyed, overwhelmed, *suicidal*, fluctuating, aggressive

Mind

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

Chest

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

Gut

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

Genitals

itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatis, 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, split, fungal, hangnails, infected, split cuticles, ridged, spoon shaped, white spots on more than 2, horizontal white lines, thickened or "horny", dark nails, pale nail bed

Legs & feet

restless legs, swollen, aching, athlete's foot, burning feet, tender heels, gout, sciatica, cold feet, tingling, *numb*, prickling

Important symptoms

Please indicate by clicking 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 or 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 rate?

Your height?

Your waist circumference? (if known)

Your hip circumference? (if known)

Your weight? (if known)

Is your weight stable, increasing or decreasing?

Did you have the recommended immunisations as a child?

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc.) State disease, age at onset and 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 any 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 often do you have a bowel movement?

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 per 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 flyer?

Are you exposed to to chemicals through your 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 times per 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 too quickly?
Do you suffer from unexplained fatigue or listlessness?

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 ever 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 infections?
Are you happy with your sex drive?

Menstruating women: please click any that you experience: pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches. Other?

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

Men only

Do you experience mood swings or depresssion?
Loss of sex drive?
Loss of motivation or drive?
Any known genito-urinary conditions?
Fertility problems?
Problems achieving or maintaining an erection?
Frequent or difficult urination?
Prostate problems
Wake at night to urinate
Difficult so start or stop urine stream
Pain or burning when urinating?

Eating habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find hard to give up?

Do you cater for a special diet in the household?
If 'yes', please specify:
Who does the cooking in your household?
Do you avoid any food for cultural/ethical reasons?
Are you allergic to any foods?
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

Your health carers

Is this your first visit to a Nutritional Therapist?
How did you find out about me?
What is your G.P.'s name?
Address
Phone
Are there any other therapists involved in your care? Please list:

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.

Signed
Date

PLEASE EMAIL THIS FORM AS SOON AS POSSIBLE TO:
michelle@mission-nutrition.co.uk

missionnutrition 3 day lifestyle diary

Name | Date

Please choose 2 fairly typical week days 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 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

Meals	**Weekday 1**	**Weekday 2**	**Day off**
Breakfast time:			
Lunch time:			
Dinner time:			
Snacks time:			
Drinks	**Weekday 1**	**Weekday 2**	**Day off**
coffees (____ sugars/cup)			
'normal' tea (____ sugars/cup)			
green/herbal tea			
fizzy drinks/cordial			
units of alcohol			
glasses of water			
other drinks....			

missionnutrition **3 day lifestyle diary**

Your routine

Please do the same for your routine

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

TERMS OF ENGAGEMENT -

BETWEEN THE BANT NUTRITIONAL THERAPIST (NT) AND HIS/HER CLIENT

The Nutritional Therapy Descriptor

Nutritional Therapy is the application of nutrition science in the promotion of health, peak performance and individual care. Nutritional therapy practitioners use a wide range of tools to assess and identify potential nutritional imbalances and understand how these may contribute to an individual's symptoms and health concerns. This approach allows them to work with individuals to address nutritional balance and help support the body towards maintaining health. Nutritional therapy is recognised as a complementary medicine and is relevant for individuals with chronic conditions, as well as those looking for support to enhance their health and wellbeing.

Practitioners consider each individual to be unique and recommend personalised nutrition and lifestyle programmes rather than a 'one size fits all' approach. Practitioners never recommend nutritional therapy as a replacement for medical advice and always refer any client with 'red flag' signs or symptoms to their medical professional. They will also frequently work alongside a medical professional and will communicate with other healthcare professionals involved in the client's care to explain any nutritional therapy programme that has been provided.

The Nutritional Therapist (NT) requests that the Client notes the following -

- The degree of benefit obtainable from Nutritional Therapy may vary between clients with similar health problems and following a similar Nutritional Therapy programme.
- Nutritional advice will be tailored to support health conditions and/or health concerns identified and agreed between both parties.
- Nutritional therapists are not permitted to diagnose, or claim to treat, medical conditions.
- Nutritional advice is not a substitute for professional medical advice and/or treatment.
- Your Nutritional Therapist may recommend food supplements and/or functional testing as part of your Nutritional Therapy programme and may receive a commission on these products or services.
- Standards of professional practice in Nutritional Therapy are governed by the CNHC Code of Conduct.
- This document only covers the practice of Nutritional Therapy within this consultation, and your practitioner will make it clear if he or she intends to step outside this boundary.

The Client understands and agrees to the following –

- I am responsible for contacting my GP about any health concerns.
- I give permission for you to contact my GP regarding any agreed aspects of my case: ☐ YES ☐ NO
- If I am receiving treatment from my GP, or any other medical provider, I should tell him/her about any nutritional strategy provided by my nutritional therapist. This is necessary because of any possible reaction between medication and the nutritional programme.
- It is important that I tell my nutritional therapist about any medical diagnosis, medication, herbal medicine, or food supplements, I am taking as this may affect the nutritional programme.
- If I am unclear about the agreed nutritional therapy programme/food supplement doses/time period, I should contact my nutritional therapist promptly for clarification.
- I must contact my nutritional therapist should I wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions.
- Recording consultations using any form of electronic media is not allowed without the written permission of both me and my Nutritional Therapist.

We understand the above and agree that our professional relationship will be based on the content of this document. We declare that all the information we share during this professional relationship is confidential and to the best of our knowledge, true and correct.

Client Name:		**NT Name:**	
Client Signature:		**NT Signature:**	
Date:		**Date:**	

This document is confidential and a signed copy must be retained by both the Client and the Nutritional Therapist (NT)

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