Diet & Lifestyle Questionnaire (DLQ)

PRIVATE AND CONFIDENTIAL

First name:	**Surname:**
Post Code and house number:	**Occupation:**
Main contact number:	**E-mail:**
Date of birth: **Age:**	**Gender:**
Height:	**Weight:**
Blood pressure (don't worry if you don't know it):	**Pulse rate** (beats per minute)**:**

How did you hear about me?

What is YOUR MAIN AIM for this consultation?

Health Concerns (please list in order of priority and continue on a separate page if necessary)	**How long have you had this?**
1.	
2.	
3.	
4.	
5.	

GP's name, address and telephone number	**Are any other therapists / clinics involved in your care? Please list.**

Current medication and supplementation

List any medicines you are taking (continue on a separate sheet if necessary)	Dose	How long have you been taking?
1.		
2.		
3.		
4.		
5.		
List any supplements, giving brand names and dosages where possible		
1.		
2.		
3.		
4.		
5.		

Please tick if you have had any of the following in the **last 6 months**

Unexplained bleeding or discharge from nipple, vagina or rectum

Blood in sputum, vomit, urine or stools

Black, tarry stools

Bleeding in pregnancy

Breast lumps

Calf swelling

Paralysis

Slurred speech

Depression/suicidal thoughts

Persistent or unexplained pain

Persistent vomiting or diarrhoea

Difficulty swallowing or breathing

Excessive thirst

Increased urination Unexplained weight loss

Loss of appetite

Painless ulcers or fissures

Unexplained bruising Persistent cough

Exercise and Lifestyle

Do you take part in any form of exercise? If so, what sort of exercise?
How many times per week and for how long?
Is this regular?
Do you take part in any forms of relaxation? If so, what?
Do you smoke? If so, how many per day? How long have you smoked for?
Have you ever smoked in the past? Is so, how many per day and when did you give up?
Do you drink alcohol? If so, how much per week and what sort? eg beer, wine, spirits
How many hours sleep do you get (on average) each night? How easily do you fall asleep? Do you wake during the night? How do you feel on waking?
Describe your energy levels during the day (morning, afternoon, evening).

I hereby sign that this is a true reflection of my present diet and lifestyle.

Signature: **Date:**

DIETARY ANALYSIS

Please list all the foods and drinks that you have over three days (2 weekdays and 1 weekend day), giving as much information as possible.

	Day 1 **Week/workday**	**Day 2** **Week/workday**	**Day 3** **Weekend**
Wake up time			
Breakfast **Time:**			
Lunch **Time:**			
Dinner **Time:**			
Water			
Other Drinks			
Snacks			
Time you go to bed:			

Please indicate which of the following are in your diet, with quantities.

	Quantity **per day**		Quantity **per day**		Quantity **per day**		Quantity **per day**		Quantity **per week**
Eggs		Fresh fruit (portions?)		Coffee		Chocolate		Fried foods	
Cheese		Fresh veg (portions?)		Tea		Sweets		White meat	
Cow's milk		Sugar (tsp)		Herbal teas		Cakes and biscuits		Oily Fish	
Bread (Slices)		Nuts		Water		Yogurt		Convenience/ canned foods	
Breakfast cereals		Seeds		Fizzy drinks		Beans/Pulses		Takeaways	

Do you add salt when cooking?	Do you add salt at the table?
Who does the cooking in your house?	Do you enjoy cooking?
Which supermarket do you normally use?	Do you ever use the internet for your shopping?
Are there any foods that you really dislike?	Is there anything that would prevent you making dietary changes?
Do you cater for any special diet in your household?	Do you avoid any foods for cultural or ethical reasons?
Have you recently changed your diet?	Do you eat on the move or when stressed?