Nutritional Health Questionnaire (NHQ)

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.**

Past Medical History

Details of any past illnesses	Year
Details of any past operations	
Recent test results (within the last 12 months)	

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.		

How many children do you have?	Number	Ages
Sons		
Daughters		

Health screen – family history

*Please indicate if any of the following conditions run in your family – **(M=male; F=female)***										
CONDITION	Grandparents				Parents		Siblings		Children	
	Paternal		Maternal							
	M	F	M	F	M	F	M	F	M	F
Arthritis										
Asthma/Eczema/Hay fever										
Cancer										
Depression/other mental health problems										
Dementia										
Diabetes										
Heart Disease/Stroke/High BP										
IBS										
Crohns, Colitis, Coeliac										
Obesity										
Osteoporosis										
Any other family-related issues of concern to you										

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).

SYMPTOM ANALYSIS

This section aims to provide your practitioner with a good overview of your general state of health and areas that may need support. Please fill it in as well as you can. This will form the basis of your consultation and will help us to help you.

Please grade the following: 3= severe/persistent, 2= moderate/regular, 1= mild/occasional. Leave blank if does not apply

Profile 1

Abdominal bloating/discomfort within an hour of a meal or a feeling of excess fullness		Stomach upset by taking vitamins	
Do not chew food properly		Stomach pains/cramps	
Halitosis (bad breath)		Sleepy after meals	
Weak, peeling, split or ridged nails		Do you feel like skipping breakfast?	
Loss of taste for meat		Undigested food in stools	
Heartburn or acid reflux		Black or tarry stools	
History of ulcers or gastritis		Sour taste in the mouth	

Profile 2

Intolerance to alcohol/easily intoxicated		Sensitive to chemicals, smoke, fumes	
Difficulty digesting fatty foods		Headache over eye	
Nausea		Greasy or shiny stools	
Pain between shoulder blades		Light or clay-coloured stools	
Bitter taste in mouth especially after meals		Haemorrhoids	
Yellowish cast to skin or eyes		Long-term use of prescription medications	

Profile 3

Food allergies and intolerances		Mucus in stool	
Abdominal bloating 1 to 2 hrs after eating		Coated tongue	
Sinus congestion, stuffy head		Alternating constipation and diarrhoea	
Excessive flatulence		Constipation	
Bizarre, vivid or nightmarish dreams		Less than one bowel movement daily	
Feel spacey or unreal		Anal irritation	

Profile 4

Need more than 8 hours sleep a night		Often feel drowsy during the day	
Need/crave tea, coffee, cigarettes throughout the day		Fuzzy thinking, confusion, or disorientation	
Irritability, mood swings or fatigue if a meal is missed		Often feel agitated, easily upset or nervous	
Cravings for sweet foods		Headaches if meals are missed/delayed	
Poor memory or concentration		Breath smells sweet	
Avoid exercise because of tiredness		Frequent urination	
Energy less than it used to be		Sweat a lot or get excessively thirsty	

Profile 5

Hard to get up in the morning		Impatient or intolerant	
Poor sleep patterns		Apathy and depression	
Difficulty in getting to sleep		Feel light-headed or dizzy on standing	
Energy slump during the day, especially in the afternoon		Highly stressed or less able to handle stress	
Feel better, more alive in the evening		Craving for salt/salty foods	
Aggressive or angry		Food allergies and intolerances	
Work over 50 hours per week		Very competitive / persistent need for achievement	

Profile 6

Fatigue, lethargy, poor stamina		Excessive hair loss	
Weight gain or difficulty losing weight		Outer third of eyebrow thins or is lost	
Frequent dieting		Depression, difficulty coping	
Cold intolerance (hands or feet)		Infertility	
Low sweating		PMS or menstrual irregularities	
Chronic constipation, IBS		Reduced libido	
Poor digestion, bloating		Poor circulation	
Dry skin and/or coarse, dull hair		Poor concentration/memory	
Carpel tunnel syndrome		Shoulder/neck pain	
Fibromyalgia		Morning headaches – wear off during the day	

Profile 7

Job involves working with chemicals		Do not wash fruit and veg. before eating	
Usually cycle to work		Smoke more than 5 cigarettes per day	
Live or work in a smoky atmosphere		Usually drink unfiltered tap water	
Live in a city or near a busy road		Drink more than one unit of alcohol per day	
Spend a lot of time in front of VDU or TV		More than three mercury amalgam fillings	
Usually eat non-organic foods		Use recreational drugs	

Profile 8

Bone deformities		Poorly developed muscles	
Back ache		Loss of muscle tone	
Osteoporosis/osteopenia		Muscle cramps	
Joint pain/stiffness		Muscle spasm/tingling	

Profile 9

Catch more than three colds year		Family history of cancer	
Prone to respiratory infections		Inflammatory conditions - eczema or asthma	
Prone to cold sores		Swollen or sore glands	
Prone to thrush or cystitis		Environmental and chemical sensitivities	
Suffer from hayfever		History of antibiotic use	
Suffer from allergy problems		Have recently taken antibiotics	

Profile 10

Do you have any known allergies or intolerances? If so, what?	What foods or drinks would you find hard to give up?
1:	1:
2:	2:
3:	3:

Migraines		Constant sore throat	
Facial puffiness		Earache	
Itchy or watery eyes		Glue ear	
Dark circles under eyes		Tinnitus	
Sinusitis		Excessive mucous	
Excessive sneezing		General joint pain or stiffness	
Muscle aches and pains		Hyperactivity	
Fluid retention		Itchy skin	
Difficulty losing weight		Psoriasis	
Difficulty gaining weight		Eczema or dermatitis	
Rapid weight fluctuations		Asthma	
Binge or compulsive eating		Hay fever	
Food cravings		Hives	

Female only questions

Are you pregnant or trying to conceive?		PMS – anxiety, irritability, tension, mood swings	
Are you breastfeeding?		PMS – sweet cravings, fatigue, headaches	
Have you ever had a miscarriage?		PMS – weight gain, breast tenderness, bloating	
Do you get thrush or cystitis?		PMS – depression, crying, forgetfulness	
Are your periods regular?		Are you peri-menopausal?	
Are your periods heavy?		Are you post-menopausal?	
Do you have hot flushes/night sweats?		Do you have/have you had fertility problems?	
Do you have endometriosis?		Do you have uterine fibroids	
Do you have excess facial or body hair?		Do you suffer from vaginal itchiness?	

Male only questions

Prostate problems		Waking to urinate at night	
Pain or burning with urination		Interruption of stream during urination	
Feeling of incomplete bowel evacuation		Decreased sexual function	
Fertility problems		Low sperm count	

Any other symptoms or issues not already covered that you feel are important

I hereby sign that this is a true reflection of my present health.

Signature: **Date:**

DIETARY ANALYSIS

Please list all the foods and drinks that you have over the next three days, giving as much information as possible.

	Day 1 Week/work-day	Day 2 Week/work-day	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	
Cows milk		Sugar (tsp)		Herbal teas		Cakes and biscuits		Oily Fish	
Bread (Slices)		Nuts		Water		Yogurt		Convenience/fast/ canned foods	
Breakfast cereals		Seeds		Fizzy drinks					

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?