**Nutritional Therapy and Wellbeing Questionnaire**

Title\_\_\_\_\_\_\_\_\_\_\_ First Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Post Code\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone numbers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please circle appropriate answers below.*

**Employment Status:**

Full time Part time Self-employed if employed please give occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Homemaker Student Retired Unemployed Disabled Not specified.

**Family Status:**

Living with Parents Single Married Separated Divorced Widowed Partnered

Any Children\_\_\_\_\_\_\_\_\_ Ages\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Profile:**

What is your main reason for seeking nutritional advice?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What outcome are you hoping to achieve?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your symptoms affecting any activities in your every day life? If yes please specify.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list any health problems that may currently be affecting you, or that you would like to focus on.**

|  |  |  |  |
| --- | --- | --- | --- |
| Health Problem (e.g Diabetes) | Management so far (e.g. GP, operation, exercise, medication, painkillers 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 etc.)\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you suspect your symptoms relate to a particular event or time in your life?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication and Remedies**

Please list anything you take regularly including GP prescribed medication, self prescribed medication, herbal remedies

or nutritional supplements.

|  |  |  |  |
| --- | --- | --- | --- |
| 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: |

**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?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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.) If so state disease, age at

onset and gender.

Grandparents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings: ­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**A DEEPER LOOK AT YOUR BODY** Please underline or circle any conditions that you regularly experience

**Head and Hair:**

Headaches, migraine, stiff neck, fuzzy headed, dizziness, poor balance, pounding head, feeling of hangover

Oily hair, dry, poor condition, brittle, thinning, dandruff, increased facial or body hair, decreased body hair

**Mind**

Forgetful, difficulty learning new things, easily confused, difficulty concentrating, easily frustrated, indecisive, fogginess

Easily distracted, can’t switch off, dyslexia, dyspraxia, panic attacks, loss of interest in daily life, no motivation

**Eyes**

Burning, gritty, protruding, prone to infection, sticky, itchy, painful, poor night vision, dry, cataracts, sensitive to light, dark circles/bags, failing eyesight, yellowish

**Ears**

Blocked, sore, itchy, watery, overly waxy, creased earlobe

**Nose**

Stuffy, congested, runny, nose bleeds, prone to snoring, sinusitis, hay fever, post-nasal dip, rhinitis, sneezing, itchy, poor sense of smell, frequent colds

**Mouth**

Sore tongue, tooth decay, mouth ulcers, cold sores, bad breath, sore throats, poor sense of taste, dry mouth, bleeding gums, excess saliva, difficulty swallowing

**Mood**

Depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can’t be bothered, hyperactive,

Cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, worried, overwhelmed, fluctuating, aggressive

**Chest**

Chest infections, asthma, bronchitis, diagnosed heart condition, chest pain, short of breath, persistent cough, wheezing

**Muscles**

Tender, sore, cramps, spasms, twitches, loss of tone, weak, stiff, frozen, restless legs, numbness

**Skin**

Dry, flaky, scaly, puffy, pale, brown patches, warts, oily, clammy, yellow, prematurely lined, change in moles, acne, boils, pimples, rosacea, eczema, dermatitis,

 psoriasis, rashes, itching, stretch marks, cellulite, easy bruising, thread veins, ringworm, allergic reactions, excessive sweating

**Hands and Nails**

Dry, cracked, eczema, sore joints, puffy, cold, numbness, tingling, feel clumsy and uncoordinated, poor circulation, fragile nails, brittle, peeling, splitting,

ridged, white spots on more than 2 nails, horizontal white lines, pitted, thickened or horny

**Joints**

Painful, inflamed, swollen, stiff, rheumatic, arthritic, sore, difficulty bending, reduced mobility, slow movement

 **Gut**

Bloated, tender, cramping, nausea, acid reflux, flatulence, belching, churning, pains, IBS, coeliac, hiatus hernia, polyps,

Diverticula, haemorrhoids, ulcers, constipation, diarrhoea, sensitive, sluggish

**Genitals**

Itchy, cystitis, thrush, ulcers, warts, herpes, prostatitis, impotence, painful intercourse, unexplained discharge, dryness, PID

**Legs and feet**

Restless legs, swollen, aching, athlete’s foot, fungal nails, burning feet, tender heels, gout, numb, tingling, cold feet, dry cracked heels

**Your daily life**

Do you enjoy daily life? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many people depend on your support? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel supported by people around you? \_\_\_\_\_\_\_ Do you feel guilty when you are relaxing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle or underline any of the following things that you may have experienced recently

*Divorce Separation Become a new parent Bereavement Moved house Changed jobs*

Are you under significant stress in any other way? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work long or irregular hours? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your workload bigger than you can manage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your job active? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you exercise or have any active hobbies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you sleep well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What do you do for relaxation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you live close to an agricultural area? \_\_\_\_\_\_\_\_\_\_\_\_ Do you smoke? If so, how many a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you heat, freeze or wrap food in plastics? \_\_\_\_\_\_\_ Are you exposed to chemicals through work or hobby? \_\_\_\_\_\_

Do you cook or wrap food in aluminium? \_\_\_\_\_\_\_\_\_\_\_ Do you regularly take antacid (indigestion) medication? \_\_\_\_\_

**Your digestion** (Please circle or underline any of the following that you regularly experience)

*Indigestion after food Indigestion between meals Nausea or vomiting Frequent stomach upsets or pain*

*Constipation Diarrhoea loose stools blood/mucus in the stools anal itching pain under the ribs.*

How many bowel movements do you have in 24 hours? \_\_\_\_\_ Have you noticed any recent change in bowel habit? \_\_\_\_\_\_\_\_\_

Have you ever had a stomach upset after foreign travel? \_\_\_\_\_\_\_\_\_\_ Have you ever had thrush or cystitis? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Energy levels**

On average how many hours of sleep do you get per night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you rate your quality of sleep? (Please circle all that apply)

*Poor Disturbed Restless Broken Not long enough Deep Restful Good Excellent*

Do you find it difficult to get going in the morning? \_\_\_\_\_\_\_\_\_\_\_ Is your energy less than you want it to be?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 find it difficult to concentrate? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Women only**

Are you pregnant or breastfeeding? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had any problems with fertility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you still menstruating? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are your periods regular? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are your periods particularly heavy/painful? \_\_\_\_\_\_\_ Do you suffer from PCOS, fibroids endometriosis? \_\_\_\_\_\_\_\_\_\_\_

Are you happy with your sex drive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What contraception do you use? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Men only**

Have you had any problems with fertility? \_\_\_\_\_\_\_ Are you happy with your sex drive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequent or difficult urination? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you experience mood swings or depression? \_\_\_\_\_\_\_\_\_\_\_\_\_

**Eating Habits**

What do you consider to be your daily eating pattern (please circle or underline all that apply).

*Less than normal Normal Over eat Binge Excessive snacking Disordered eating*

Which meals do you eat each day?

*Breakfast Lunch Supper Mid- morning snack Mid-afternoon snack Evening snack*

Which are your favourite foods? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which foods do you like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which foods do you crave? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Which foods would you find 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? \_\_\_\_\_\_\_ Have you recently changed your diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you suspect any foods don’t agree with you? \_\_\_\_\_\_\_\_\_\_\_ 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 properly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you drink alcohol, if yes how much per week? \_\_\_\_\_\_\_\_\_ What percentage, if any, of your food is organic? \_\_\_\_\_\_\_\_\_\_

How motivated are you in changing the way you eat? (please circle or underline the answer you most agree with)

*I am ready and willing to try anything that might improve my condition and quality of life*

*I feel I can cope with a moderate amount of change.*

*I feel anxious about changing my diet, and hope it will fit into my lifestyle.*

How willing are you to experiment and try new foods? (please circle or underline the answer you most agree with)

*I am ready and willing to try anything that might improve my condition and quality of life*

*I feel I can cope with a moderate amount of change.*

*I feel anxious about changing my diet, and hope it will fit into my lifestyle*

 **Health Care Providers**

Is this your first visit to a Nutritional Therapist? \_\_\_\_\_\_\_\_\_ How did you find out about me? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please now provide name and contact details of your GP. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Thank you for taking the time to complete this questionnaire.**

**Please now complete the separate 3 day food diary.**

*I have disclosed all the relevant information applicable to this questionnaire and my health status at this point in*

*time. I consent for the information provided to be used by my Nutritional Therapist and if necessary for her to liaise*

*further with appropriate health professionals.*

Signed\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANY ADDITIONAL NOTES**