**ALL INFORMATION IS PRIVATE AND CONFIDENTIAL**

**PLEASE ANSWER ALL QUESTIONS AS FULLY AS POSSIBLE**

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| **PERSONAL DETAILS** |
| NAME |  | EMAIL |  |
| TELEPHONE - DAYTIME |  | EVENING |  |
| ADDRESS |  |
| DATE OF BIRTH |  | OCCUPATION |  |
| HEIGHT (cm) |  | WEIGHT (Kg) |  | IDEAL WEIGHT (Kg) |  |
| **YOUR MAIN REASONS FOR VISIT** |
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| **PERSONAL HISTORY** |
| DO YOU TAKE ANY MEDIACTIONS?Please give name, dose and reason |  |
| DO YOU TAKE ANY SUPPLEMENTS?Please give name, dose and reason |  |
| PLEASE LIST ANY MAJOR HEALTH INCIDENTS FROM THE PAST (eg asthma, gall bladder removed) |  |
| HAVE YOU HAD ANY PREVIOUS FUNCTIONAL TESTS? IF SO, WHAT?(eg food allergy, stool analysis) |  |
| **FAMILY HISTORY** |
|  | YES? (🗸) | WHICH FAMILY MEMBER? |
| CANCER |  |  |
| DIABETES |  |  |
| HIGH CHOLESTEROL |  |  |
| HIGH BLOOD PRESSURE |  |  |
| CARDIOVASCULAR DISEASE |  |  |
| LIVER OR GALLBLADDER DISEASE |  |  |
| **LIFESTYLE** |
| Do you have a stressful lifestyle? |  | How many hours of sleep do you get a night? |  |
| Do you sleep well? If no, describe why not. |  |
| Do you have any dietary restrictions (eg vegan) |  | Do you chew your food thoroughly, or eat in a hurry? |  |
| Do you add salt to your food when cooking or at the table? If so, which? |  |  |  |
| Do you have any known food allergies or intolerances? If so, to what? |  |
| Do you crave any foods? If so, what? |  |
| How often do you exercise per week? What kind of exercise do you do? |  |

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| Do you smoke? If so, how many per day? |  | Do you use recreational drugs? If so, which? |  |
| How many units of alcohol do you drink per week? |  | What is your preferred alcoholic drink? |  |
| How many glasses of water do you drink a day? |  | Do you normally drink *unfiltered* tap water? |  |
| Do you drink tea/coffee? How many per day?  |  |
| Do you add milk, sugar or sweeteners? Which? How many? |  |
| Do you wash fruit and vegetables before eating? |  | Do you often buy organic produce? Which foods? |  |
| Do you have any mercury dental fillings? How many? |  | Do you know if your blood pressure is high, low or normal? |  |
| **DIET** |
| Do you like to cook? |  | Do you normally choose white or brown rice? |  |
| Do normally choose white or wholemeal bread/pasta? |  | How often do you eat dairy foods (milk, butter, cheese, cream, yoghurt) in a day? |  |
| How many times a week do you eat biscuits/cakes? |  | How many portions of fresh fruit do you eat a day?  |  |
| Do you boil or steam your vegetables when cooking? |  | How many times a week do you eat salads? |  |
| Which oils do you use for cooking (roasting/frying)? |  | Do you eat nuts or seeds? How often / week? |  |
| How many times a week do you eat fish? Which kinds? |  |
| Do you eat processed foods eg cheese, meat, ready meals etc. If so, which and how often? |  |
| How often do you eat takeaway? What kinds of takeaway do you eat? |  |
| Do you eat smoked fish or smoked meat? If so, how often? |  | Do you eat tuna, swordfish or shark? If so, how often? |  |
| Do you suffer from bloating after eating? If so, which foods seem to trigger it? |  |
| Do you suffer from a ‘heavy’ feeling within half an hour of eating? |  | Do you suffer from flatulence? |  |
| Do you have a bowel movement every day? If not, how often? |  | Do you suffer from diarrhoea? |  |
| If you miss a meal, do you suffer with any symptoms such as headaches, weakness, irritability, poor concentration, shakiness, anxiety, cravings for sweets or stimulants (eg coffee or cigarettes)? If so, which? |  |
| **HEALTH** |
| Are you prone to colds and infections? How often a year? |  | Do you gums bleed when you brush them? |  |
| Do you suffer from dental decay? |  | Do you suffer from varicose veins? |  |
| Do you suffer from easy bruising? |  | Are you anaemic? Or suffer from skin pallor?If so, which? |  |
| Do you suffer from acne? |  | Do you have any skin rashes or itchy skin? |  |
| Do you suffer from eczema or psoriasis? If so, which? |  | Do you suffer from dry skin? |  |
| Do you have cataracts or age spots? |  | Do you have dry or brittle hair? |  |
| Do you suffer from hair loss? |  | Is this male patterned balding? |  |
| Do you suffer from asthma, hayfever or sinusitis? If so, which? |  | Do you suffer from depression? |  |
| Do you ever feel rundown or overwhelmed? |  | Do you find it hard to get up in the morning? |  |
| Do you suffer from fatigue/lethargy that is not relived by sleep? |  | Are you sensitive to the cold? |  |
| Do you find it hard to lose weight? |  | Do you find it hard to put on weight? |  |
| Do you often feel sluggish and slow to think or move? |  | Do you have a diminished libido? |  |

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| Do you have poor night vision? |  | Do you suffer from red, gritty or burning eyes? Or eye lesions? If so, which? |  |
| Do you suffer from cold sores? |  | Do you ever get a sore tongue? |  |
| Do you get dry, cracking, peeling lips? |  | Do you get cracks at the corners of your mouth? |  |
| Do you suffer from mouth ulcers? Or gastric ulcers? If so, which and do you know what triggers it? |  |
| Do you suffer from heartburn? If so, list any known triggers. |  |
| Are you prone to joint pain or any arthritis? |  | Do you get muscle cramps? |  |
| Do you get any numbness or pins and needles in your hands or feet? |  | Do you get water retention? |  |
| Do you suffer from thrush, jock itch or athletes foot?If so, which? |  | Do you suffer from cystitis? |  |
| Are your nails weak, brittle, peeling or ridged? |  | Do you have white spots on your fingernails? |  |
| Do you have a poor sense of taste or smell?  |  | Can you remember your dreams? |  |
| Do you suffer from tinnitus or hearing loss?  |  | Do have a history of taking steroids? |  |
| Do you suffer from headaches or migraines?If so, what triggers these? |  |
| Do you regularly use pain-killers like Neurofen or paracetemol? If so, which and how often? |  |
| Have you a history of taking antibiotics? If so, why? |  |
| Have you recently taken antibiotics? If so, when and why? |  |
| Do you have a history of parasitic infection? |  | Do you suffer with itching around the rectum? |  |
| Have you recently travelled abroad? If so, where? |  |
| Do you suffer from environmental or chemical sensitivities (eg to soaps, perfumes, pollution etc)? |  | Do you have an intolerance to alcohol? |  |
| Do you suffer from constipation or diarrhoea? If so, which |  | How often do you have a bowel movement? |  |
| Are stools hard and difficult to pass? |  | Are stools ever light or clay coloured? |  |
| Do you suffer from bloating? If so, can you name the triggers? |  | Do you suffer from flatulence? |  |
| Do you have any diagnosed conditions such as IBS, CFS, Crohn’s disease or Ulcerative colitis, Raynaud’s disease, Carpal tunnel syndrome, rheumatoid arthritis, diabetes, autoimmune disease, etc? If so, which? |  |
| **WOMENS HEALTH** |
| Do suffer with PMS? Please list your symptoms (eg breast tenderness, irritability, mood swings, headaches, water retention, anxiety, tension, bloating, forgetfulness, depression, crying, fatigue, craving sweets) |  |
| Do you suffer with heavy periods? |  | Do you suffer from prolonged periods or ‘spotting’ between periods? If so, which? |  |
| Do you have a history of fertility problems? |  | Do you suffer with period pains? |  |
| Are you pregnant or trying to become pregnant? If so, which? |  | Are you breast-feeding? How old is your baby? |  |
| Do you have a history of miscarriages? |  | Do you use the contraceptive pill or IUD? |  |
| Are you peri-menopausal, menopausal or post-menopausal? |  | Are you taking HRT? If so, for how long? |  |
| Are your periods regular? If not, what seems to be the pattern? |  |
| **MENS HEALTH** |
| Do suffer any prostate related problems? If so, what? |  |
| Do you wake regularly at night to urinate? |  | Is it difficult to start and stop urine flow? |  |
| Do you suffer pain or burning sensation when urinating? |  | Do you have decreased sexual function? |  |

**PLEASE USE THE SPACE BELOW TO NOTE ANY OTHER INFORMATION WHICH YOU THINK MAY BE RELEVANT**

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| **GP’s DETAILS**Sometimes it is advisable to contact the GP whether to request a laboratory test that may be done via the NHS or to inform them of the nutritional therapy treatment programme. A client’s GP will never be contacted without prior knowledge and consent. **GP NAME:.................................................................................................................................................................................................................****PRACTISE ADDRESS:..............................................................................................................................................................................................****CONTACT NUMBER:.................................................................................................................................................................................................** |

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| **DECLARATION**I hereby confirm that this information is correct to the best of my knowledge and that I am not with-holding any important information which may hinder the help of a nutritional therapist.**SIGNED:.......................................................................................................................DATE:....................................................................................**  |

**THANK YOU FOR COMPLETING THE QUESTIONNAIRE**

**PLEASE RETURN IT VIA EMAIL TO samantha@nutritionista.co.uk**

**OR BY POST TO**

**NUTRITIONISTA, 9 PARK AVENUE NORTH, LONDON, N8 7RU**

**I LOOK FORWARD TO MEETING YOU AT YOUR INITIAL CONSULTATION**

**PLEASE FILL THIS SECTION IN AS THOROUGHLY AND HONESTLY AS POSSIBLE AS MUCH OF THE CONSULTATION WILL BE BASED ON YOUR CURRENT EATING PRACTISES**

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| --- |
| **TYPICAL WEEKDAY DIET:** |
|  | **Breakfast**  | **Lunch**  | **Dinner**  |
| **DAY 1** |  |  |  |
| **Snacks/****drinks** |  |  |  |
|  | **Breakfast**  | **Lunch**  | **Dinner**  |
| **DAY 2** |  |  |  |
| **Snacks/****drinks** |  |  |  |

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| **TYPICAL WEEKEND DIET:** |
|  | **Breakfast**  | **Lunch**  | **Dinner**  |
| **SAT** |  |  |  |
| **Snacks/****drinks** |  |  |  |
|  | **Breakfast**  | **Lunch**  | **Dinner**  |
| **SUN** |  |  |  |
| **Snacks/****drinks** |  |  |  |

**TERMS OF ENGAGEMENT**

Good nutrition helps build the body’s natural strength and resistance, however, no claim is made as to the efficacy of any nutritional protocols. The aim of Nutritional Therapy is to facilitate the body’s own biochemical re-balance of to enable self-healing and to alleviate adverse symptoms. The degree of benefit obtainable from Nutritional Therapy may vary between clients with similar health problems and following a similar Nutritional Therapy programme.

**The Client**

* The above health assessment questionnaire must be completed in full and returned to your nutritional therapy practitioner at least 48 hours before the initial consultation. If it is not returned within this time frame, the consultation will most likely be postponed.
* Your involvement in the consultation will include helping to determine the best treatment options for you. Following the initial consultation you will be sent a full report including diet and lifestyle recommendations and any nutritional supplements for information on suggested laboratory testing. Efficacy of the treatment will depend on your compliance with the recommendations. No responsibility can be acceptied in the case of non-compliance or altering the nutritional therapy practitioners recommendations.
* You must contact your nutritional therapy practitioner should you wish to continue any specified supplement programme for longer than the original agreed period, to avoid any potential adverse reactions. No responsibility can be taken if the supplement programme is continued beyond the period of specified time when not receiving nutritional guidance.
* If you are unclear about the agreed nutritional therapy programme/food supplement doses/time period, you should contact your nutritional therapy practitioner promptly for clarification.
* You are responsible for contacting your GP for any health concerns.
* If you are not being treated by your GP, you should still let him/her know that you are receiving nutritional therapy.
* If you are receiving treatment from your GP, or any other medical provider, you should tell them about any nutritional strategy provided by a nutritional therapy practitioner. Similarly, it is the responsiblility of the client to keep the GP informed
* In the event that there is extensive information regarding a complicated medical history, details provided before or during the consultation (ie above and beyond the scope of the Health Assessment Questionnaire) Nutritionista reserves the right to make an additional charge pro-rata for the extra time spent in research.
* It is important that you tell your nutritional therapy practitioner about any medical diagnosis, modification, herbal medicine, or food supplements you are taking as this may affect the nutritional programme.
* You are advised to report any concerns about Nutritional Therapy promptly to your nutritional therapist for discussion and action.

**The Nutritional Therapist**

* Nutritional therapists are not permitted to diagnose or claim to treat medical condition(s). Nutritional advice is not a substitute for professional medical advice and/or treatment.
* Nutritional advice will be tailored to support diagnosed conditions and/or health concerns identified and agreed between both parties and based on the information given on the Health Assessment Questionnaire and in the consultation. No responsibility can be accepted when diagnosed medical conditions have been omitted or medication details have not been fully disclosed either initially or during the course of following the nutritional therapy programme.
* Cancellation of consultations must be made with 48 hours notice (or 2 business days) prior to the time of the consultation or 30% of the consultation fee will be charged. 50% of the consultation fee will be charged when cancellation occurs with 24 hours or less notice. Postponing an appointment will require 24 hours polite notice at nutritional therapist’s discretion, else it will be treated in the same manner and incur the same fees as if a cancellation.
* Should a significant disease (eg Anthrax. Cholera, TB, etc.) be clinically identified during the consultation, it is a statutory requirement that such infectious diseases are notified to the Medical Officer of Health (MOH) in the district where you reside.

**Confidentiality**

* All your information and records are confidential and no disclosure will be made to a third party, including members of your family, without your written consent, except where it is required by due process of law, whether that be by statue, statutory instrument, order of any court of competent jurisdiction.
* No third party, including assistants and members of your family, may be present during the course of the consultation without your express consent.
* Under Freedom of Information Act (HMSO 2000) you have the right to access your own records.

**By signing the declaration below you indicate that you understand and agree to be bound by the Terms and Conditions.**

**I understand the above and agree that our professional relationship will be based on the content of this document.**

**Signed by Client:.....................................................................................................................Date:..........................................**

**Signed by Nutritional Therapy Practitioner...........................................................................Date:..........................................**

*Samantha Josephs BA(Hons) Dip (BCNH)*

(One signed copy of the above is kept by both parties)

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