



newlifenuitration

Please return to: Clare Shepherd
The Coach House
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Broomhill
Sheffield
S10 5BY
Tel: 07860 788537

NUTRITIONAL THERAPY questionnaire

All information provided is treated in the strictest confidence. The purpose of this document is to understand your overall health and wellbeing. All of the questions are relevant and need to be answered. Once completed please return to The Stillpoint Practice a **minimum of 3 days prior to your appointment.**

Name Date
Address
Postcode E-mail
Tel: Home Mobile
Date of birth Age Height Weight
Occupation Marital status?
How did you hear about newlifenuitration/Clare Shepherd?.....
Name & address of GP

Health profile

Please make a list of all the health problems you would like to clear up in order of importance, and indicate how long you have had these problems, i.e. headaches 5 years (continue on a separate sheet if you need more space)

Health problem	Duration
1.
2.
3.
4.
5.

Some of the following questions are duplicated on the questionnaire. Please complete all sections.

Please list all medications you take.....
.....
.....

List past surgical procedures & dates

List vaccinations (incl childhood vaccinations) and dates (if known)

Please list any childhood illnesses

List any supplements you take, stating the reason

List any alternative treatments you are receiving and for what reason

Current Health

Please indicate the frequency and severity of the following symptoms - grading where possible :

0 = never 1 = rarely 2 = occasionally 3 = often/always

- | | | |
|---------------------------------------|---------------------------------|--|
| Thin/premature grey hair | Anger/irritation | Cystitis/Urine infections |
| Dandruff | Palpitations | Water Retention |
| Dry eyes | High cholesterol | Thrush/Candida |
| Earache/Glue Ear | High blood pressure | Excessive sweating |
| Hayfever/Rhinitis | Dizziness | Jittery if drink coffee |
| Runny Nose | Pins and Needles | PMT |
| Catarrh/sinus | Numb fingers and toes | Blood sugar issues |
| Coughs/colds | Varicose Veins | Bone loss |
| Mouth ulcers | Asthma | Excessive thirst |
| Bleeding gums | Other breathing problems | Anorexia or Bulimia? |
| Clench or grind teeth | Do you smoke? | Weight gain/loss |
| Headaches/Migraine | Allergies | Dermatitis |
| Tiredness/fatigue | Acid indigestion | Eczema/Psoriasis |
| Low energy | Nausea | Skin rashes/Acne |
| Insomnia | Abdominal pain/discomfort | Flaky skin/dandruff |
| Seasonal sadness | Bloating | Aching joints/muscles |
| Poor memory/concentration | Diarrhoea/Colitis | Muscle cramps |
| Mood swings | Constipation | White spots on nails |
| Worry/anxiety | Flatulence/wind | Brittle/ridged nails |
| Depression | | |

How is your creativity and motivation now?..... Has this changed in the last few years?.....

Energy: Best time of day? Worst time of day?

Personal History

How was your mother's health during pregnancy with you/siblings?

How old was she when you were born? How was your health at birth?

Were you breast-fed? If so, for how long? How old are your siblings?

List vaccinations (incl. childhood vaccinations) and dates (if known)

Please list any childhood illnesses

List past surgical procedures & dates

Hereditary Profile:

What illnesses is/was your mother prone to?

What illnesses is/was your father prone to?

What illnesses are/were your siblings prone to?

What illnesses is/was your maternal grandmother prone to?

What illnesses is/was your maternal grandfather prone to?

What illnesses is/was your paternal grandmother prone to?

What illnesses is/was your paternal grandfather prone to?

Does anyone in your family currently suffer from the following? Please circle

- | | | | |
|----------|-----------------|--------------|------------------|
| Asthma | Eczema | Hayfever | Arthritis |
| Diabetes | Coeliac Disease | Migraines | Thyroid problems |
| IBS | Cancer | Osteoporosis | Heart Disease |

Food allergy/intolerance

Diet and Lifestyle: Please delete as appropriate:

Yes/No	Do you add sugar to your food and drink every day?
Yes/No	Do you eat foods with added sugars almost every day?
Yes/No	Do you use salt in your food?
Yes/No	Do you drink more than one cup of coffee most days?
Yes/No	Do you drink more than 3 cups of tea most days?
Yes/No	Do you drink fizzy drinks?
Yes/No	Do you drink more than 1 glass of wine/1 pint of beer/1 spirits measure per day?
Yes/No	Do you eat dried foods more than twice a week?
Yes/No	Do you eat processed 'fast food' more than twice a week?
Yes/No	Do you eat red meat more than twice a week?
Yes/No	Do you often eat foods containing preservatives or additives?
Yes/No	Do you eat chocolates or sweets more than twice per week?
Yes/No	Does less than a third of your diet consist of raw fruit and vegetables?
Yes/No	Do you drink less than half a pint of plain water per day?
Yes/No	Do you normally eat white rice, flour or bread rather than whole grain?
Yes/No	Do you drink more than 3 pints of milk a week?
Yes/No	Do you eat more than 3 slices of bread per day on average?
Yes/No	Are there some foods you feel 'addicted' to?
Yes/No	Do you eat oily fish less than twice per week and/or seeds less than daily?
Yes/No	Do you suffer from any allergies?
Yes/No	Are you more than a stone or 7kg overweight?
Yes/No	Do you do exercise that increases your heart rate for 20 minutes at least 3 times/week?
Yes/No	Does your work involve strenuous physical activity?
Yes/No	Do you smoke more than 5 cigarettes most days or take recreational drugs?
Yes/No	Do you take any vitamins/supplements/herbal remedies? Please give details:

Diet Analysis

How would you describe your appetite? (eg. poor, average, good, etc)

Please give an indication of a typical daily diet including fluid intake:

Breakfast

.....

Mid morning

.....

Lunch

.....

Mid afternoon

.....

Dinner

.....

Supper

Are you vegetarian or vegan? YES / NO / NEITHER Are you on a special diet? If yes, which?

Which best describes your urine? (Please circle as appropriate) Clear Very pale Yellow Dark yellow Orange Smelly

Have you been treated for stomach upset / diarrhea / parasites after traveling abroad? YES/NO

If yes, what was the treatment for? And have the symptoms stopped?

.....

Please give any other information that you think is relevant

.....

.....

.....

.....

It is important that you disclose any medical diagnosis, medications, herbal or other medicine, or dietary supplements that you are taking to avoid potential adverse reactions.

Disclaimer

Nutritional therapy is not intended to replace the relationship with your primary health care provider. You should always consult your GP if you require medical attention or have symptoms that are causing concern.

Client information is strictly confidential and will not be released to anyone including your GP unless specific permission by you has been given. You are encouraged to discuss your nutritional program with your GP.

Cancellation policy

I understand that the Stillpoint Practice have a cancellation policy which states that 48 hours cancellation is required for any appointment. I understand that the full fee will be charged if I do not attend my scheduled appointment and have not given The Stillpoint Practice sufficient notice as described above.

Declaration

The information provided above is to the best of my knowledge true and accurate. I have read and agree with the above cancellation policy.

Signature Date

ADDITIONAL QUESTIONS

MEN ONLY

Is your sperm count normal? Yes/No
 Is your erectile function normal? Yes/No
 Pain or burning when urinating? Yes/No
 Prostate problems? Yes/No

Is your sperm motility normal? Yes/No
 Does your urine flow weakly? Yes/No
 Wake regularly to urinate? Yes/No
 Is your hair receding? Yes/No

WOMEN ONLY

Menstruation and Hormone Profile

What age did your periods start?
 Is your cycle 28 days?
 Duration of bleed ____ days.
 Colour of blood? Red/brown/black
 Do you suffer from pre-menstrual bloatedness/tiredness/irritability/depression/breast tenderness/headaches? Yes/No
 Do you crave chocolate when menstruating? Yes/No

Did you have any problems?
 If not, are they regular?
 Blood flow light/heavy/flooding
 Consistency? Liquid/thick/clots

Have you taken the contraceptive pill? Yes/No
 Do you have a coil fitted?
 Are you pregnant?
 Are you trying to become pregnant?
 Are you peri/post menopausal?
 Have you had a hysterectomy?
 Have you taken HRT?

At what age/for how long? Any side effects?
 If so, how many weeks?
 How long have you been trying?
 Any symptoms?
 If so, were your ovaries removed?
 If so, for how long? Any side effects?

Do you have?
 Vaginal discharge/itchiness/dryness
 Endometriosis

Breast fibroids
 Uterine fibroids

Excess body or facial hair
 PCOS

Have you?
 Had a miscarriage? Yes/No
 Had pregnancy complications? Yes/No
 Had labour complications? Yes/No
 Breast-fed? Yes/No
 Had IUI or IVF treatment? Yes/No

How many weeks?
 Details:
 Details:
 For how long?
 Details and dates:

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