newlifenutrition

Please return to: Clare Shepherd
The Coach House
11 Tapton House Road
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 above address **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 newlifenutrition/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**
..... Dandruff
..... Dry eyes
..... Earache/Glue Ear
..... Hayfever/Rhinitis
..... Runny Nose
..... Catarrh/sinus
..... Coughs/colds
..... Mouth ulcers
..... Bleeding gums
..... Clench or grind teeth
..... Headaches/Migraine
..... **Tiredness/fatigue**
..... Low energy
..... Insomnia
..... Seasonal sadness
..... Poor memory/concentration
..... Mood swings
..... Worry/anxiety
..... Depression

..... Anger/irritation
..... **Palpitations**
..... High cholesterol
..... High blood pressure
..... Dizziness
..... Pins and Needles
..... Numb fingers and toes
..... Varicose Veins
..... **Asthma**
..... Other breathing problems
..... Do you smoke?
..... **Allergies**
..... **Acid indigestion**
..... Nausea
..... Abdominal pain/discomfort
..... Bloating
..... Diarrhoea/Colitis
..... Constipation
..... Flatulence/wind

..... **Cystitis/Urine infections**
..... Water Retention
..... **Thrush/Candida**
..... Excessive sweating
..... Jittery if drink coffee
..... PMT
..... Blood sugar issues
..... Bone loss
..... Excessive thirst
..... Anorexia or Bulimia?
..... Weight gain/loss
..... **Dermatitis**
..... Eczema/Psoriasis
..... Skin rashes/Acne
..... Flaky skin/dandruff
..... **Aching joints/muscles**
..... Muscle cramps
..... **White spots on nails**
..... Brittle/ridged nails

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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 newlifenutrition has 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 sufficient notice as described above.

Newsletters

Every quarter (4 times/year) I send out a Newsletter from newlifenutrition giving seasonal information, recipes, updates to the events offered by newlifenutrition, special offers and discounts. Your email address will automatically be added to the newlifenutrition database for the purpose of communication regarding any services you pay for.
If you prefer NOT to receive the newsletter however, please tick this box. ☐ You can unsubscribe at any time in the future.

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 sperm motility normal?	Yes/No
Is your erectile function normal?	Yes/No	Does your urine flow weakly?	Yes/No
Pain or burning when urinating?	Yes/No	Wake regularly to urinate?	Yes/No
Prostate problems?	Yes/No	Is your hair receding?	Yes/No

WOMEN ONLY

Menstruation and Hormone Profile

What age did your periods start? ……	Did you have any problems? ……
Is your cycle 28 days? ……	If not, are they regular? ……
Duration of bleed _____ days.	Blood flow light/heavy/flooding ……
Colour of blood? Red/brown/black	Consistency? Liquid/thick/clots

Do you suffer from pre-menstrual bloatedness/tiredness/irritability/depression/breast tenderness/headaches? Yes/No

Do you crave chocolate when menstruating? Yes/No

Have you taken the contraceptive pill? Yes/No	At what age/for how long? …… Any side effects? ……
Do you have a coil fitted? ……	
Are you pregnant? ……	If so, how many weeks? ……
Are you trying to become pregnant? ……	How long have you been trying? ……
Are you peri/post menopausal? ……	Any symptoms? ……
Have you had a hysterectomy? ……	If so, were your ovaries removed? ……
Have you taken HRT? ……	If so, for how long? …… Any side effects? ……

Do you have?

Vaginal discharge/itchiness/dryness	Breast fibroids	Excess body or facial hair
Endometriosis	Uterine fibroids	PCOS

Have you?

Had a miscarriage? Yes/No	How many weeks? ……
Had pregnancy complications? Yes/No	Details: ……
Had labour complications? Yes/No	Details: ……
Breast-fed? Yes/No	For how long? ……
Had IUI or IVF treatment? Yes/No	Details and dates: ……