

Nutritional Assessment Questionnaire

Please print this document, fill in your address details on this page, and then complete the following pages giving as much information as you can, and send it to:

Martina Watts BA, Dip.ION
Dolphin House Clinic
14 New Road, Brighton, East Sussex
United Kingdom BN1 1UF

When you have completed the questionnaire, please telephone the Dolphin House Clinic (tel: 01273 324790) to book a convenient appointment, or to arrange a telephone consultation.

Martina Watts

Please fill in your address details below before continuing...thank you.

Client full name	
Street Address – 1	
Street Address – 2	
Town	
County	
Postal code	
Country	

Nutritional Assessment Questionnaire

First Name: _____ Last Name: _____
Email Address: _____ Tel: _____
Occupation: _____ Weight: _____ Height: _____ Age: _____

PART I :

Please list up to 5 health concerns in order of importance:

HEALTH PROBLEM	DURATION
1	
2	
3	
4	
5	

What medications do you take for these? (state daily dosage). _____

What other illnesses have you had in the past 10 years ? _____

What is your normal blood pressure ? (Don't worry if you don't know) _____

What is your normal pulse-rate per minute ? _____

(You should be sitting down relaxed and calm when you take your pulse. Your pulse can be found inside the bony protruberance on the thumb side of your wrist. Count the number of beats in 60 seconds)

HEREDITY PROFILE

Do you have any children ? _____ Do they suffer any particular illnesses? _____

What illnesses is/was your father prone to ? _____

What illnesses is/was your mother prone to ? _____

What illnesses are/were your siblings prone to ? _____

LIFESTYLE

How many times do you exercise per week ? _____ Do you feel guilty when relaxing ? _____

Do you work more than 60 hrs per week ? _____ Are you especially competitive ? _____

Do you smoke more than 5 cigarettes per day ? _____ Do you easily become angry ? _____

Do you live or work in a smoky atmosphere ? _____ Is your energy less now than it used to be ? _____

Do you drink over 1 unit of alcohol per day ? _____ Are you unclear about your goals in life ? _____

Do you spend more than 2 hrs/wk in traffic ? _____ Do you work harder than most people ? _____

Do you spend much time by a TV or VDU ? _____ Do you have difficulty getting to sleep ? _____

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PART II

Please tick all of the symptoms that you are experiencing:

Section 1 – Upper Gastrointestinal System			
Belching or gas within 1 hour of a meal		Do you feel like skipping breakfast	
Heartburn or Acid Reflux		Do you feel better if you don't eat	
Bloating shortly after eating		Often sleepy after meals	
Bad breath (Halitosis)		Fingernails which chip, peel, or break easily	
Stomach upset by taking vitamin supplements		Stomach pains or cramps	
Sense of excess fullness after meals		Do you use indigestion tablets	
Hurried eating habits		Undigested food in stools	
Anaemia unresponsive to Iron		Diarrhoea after meals	

Section 2 – Liver and Gallbladder			
Pain between shoulder blades		History of drug or alcohol abuse	
Stomach upset by greasy foods		History of hepatitis	
Nausea		Long-term use of prescription medications	
Light or clay-coloured stools		Sensitive to chemicals (eg perfume, cleaning solvents, insecticides, car exhausts, etc)	
Gallbladder removed ?		Hurried eating habits	
Easily intoxicated by alcohol		Chronic Fatigue or Fibromyalgia	

Section 3 – Small Intestine			
Food allergies		Are there foods you could not give up ?	
Abdominal bloating 1-2 hours after eating		Asthma, sinus infections, stuffy nose	
Specific foods make you tired or bloated		Sometimes feel 'spacey' or unreal	
Pulse speeds up after eating		Alternating constipation and diarrhoea	
Airborne allergies ? (e.g. hay fever)		Do you suffer from Hives ?	

Section 4 – Large Intestine			
Anus itches		Less than 1 bowel movement per day	
Coated tongue		Stools loose or not well formed	
Feel worse in musty or mouldy atmosphere		Irritable bowel or mucus colitis	
Fungus or yeast infections (e.g. nail fungus, athlete's foot, thrush)		Blood in stools	
Stools hard or difficult to pass		Mucus in stools	
History of parasite infection		Excessive or foul lower bowel gas	
Cramps in lower abdominal region		Bad breath or strong body odours	

Nutritional Assessment Questionnaire

PART II ...cont'd

Please tick all of the symptoms that you are experiencing:

Section 5 – Cardiovascular			
Blood pressure above 140/90		Are you overweight ?	
High cholesterol		Do you seldom exercise vigorously ?	
Family history of heart disease		Do you smoke, drink, or use recreational drugs ?	

Section 6 – Immune System			
Never get sick		Itchy skin or dermatitis	
Runny nose		Cysts, boils or rashes	
Cough which produces mucus		Frequent colds or 'flu	
Frequent infections: ear, sinus, lung, skin, bladder kidney.		History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition	

Section 7 – Men Only			
Prostate problems		Waking regularly to urinate at night	
Difficult to start & stop urine stream		Decreased sexual function	
Pain or burning sensation when urinating		Constipation – chronic	

Section 8 – Women Only			
Depression during periods		Breast fibroids – benign masses	
Mood swings associated with periods – PMS		Vaginal discharge and itchiness	
Crave chocolate around periods		Vaginal dryness	
Breast tenderness associated with cycle		Excess facial or body hair	
Excessive menstrual flow		Hot Flushes	
Minimal blood flow during periods		Endometriosis	
Occasional skipped periods		Uterine Fibroids	

Section 9 – Adrenal			
Insomnia		Crave salty foods	
Slow starter in the morning		Muscles easily fatigued	
Feel wired or jittery when drinking coffee		Chronic fatigue, or feel drowsy often	
Clench or grind teeth		<u>Afternoon</u> yawning	
Calm on the outside, troubled inside		<u>Afternoon</u> headache	
Become dizzy when suddenly standing up		Allergies and /or hives	

Nutritional Assessment Questionnaire

PART II ...cont'd

Please tick all of the symptoms that you are experiencing:

Section 10 – Thyroid			
Allergic to Iodine		Mentally sluggish, reduced initiative	
Difficulty gaining weight, even with large appetite		Easily fatigued, sleepy during the day	
Nervous, emotional, can't work under pressure		Sensitive to cold – poor circulation	
Inward trembling		Constipation – chronic	
Flush easily		Difficulty losing weight	
Fast pulse at rest		Loss of lateral third of eyebrow	
Intolerance to high temperatures		Seasonal sadness	

Section 11 – Sugar Handling			
Awaken a few hours after falling asleep, hard to get back to sleep		Fatigue that is relieved by eating	
Crave sweets		Headaches if meals are skipped or delayed	
Eat desserts or sugary snacks		Irritable before meals	
Binge or uncontrolled eating		Shaky if meals are delayed	
Excessive appetite		Family members with diabetes	
Crave coffee or sugar in the afternoon		Frequent thirst	
Sleepy in afternoon		Frequent urination	

Section 12 – Essential Fatty Acids			
Suffer from PMS / PMT		Suffer from Dry Eyes	
History of infertility		Experience excessive thirst or sweating	
Poor memory & concentration		Dry flaky skin or Dandruff	

Section 13 – Vitamin and Mineral Needs			
Vulnerable to insect bites		Sore tongue	
Numbness tingling or itching in extremities		Pale skin	
Depressed		Muscles easily fatigued	
Worrier, apprehensive, anxious		Slow wound healing	
Easily exhausted		Bone Loss	
Teeth grinding		MSG Sensitivity	
Wake up without remembering dreams		Take contraceptive pill	
Small bumps on back of arms		Sensitive to strong light at night	
Nosebleeds, or tendency to bruise easily		Bleeding gums, especially when brushing teeth	
White spots on fingernails		Muscle cramps	
Strong foot odour		Decreased sense of taste or smell	

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PART III – DIET ANALYSIS

Please tick all the questions you would answer 'YES', or fill in the *number of times* you eat the food referred to.

DIET QUESTIONNAIRE			
How many teaspoons of sugar do you add to food or drink each day ?		Do you wash fruit and vegetables before eating ?	
Do you add salt to your food ?		Do you normally eat white rice or products made with white flour ?	
How many coffees do you drink per day ?		How many slices of bread or rolls do you eat per week ?	
How many cups of tea per day ?		How many pints of milk do you drink in a week ?	
How many times per week do you eat chocolate or confectionary ?		How many times do you eat white meat per week ? <i>(Poultry or fish)</i>	
What is your usual alcoholic drink ?		How many times do you eat red meat per week ? <i>(Beef, pork, lamb, or game)</i>	
..and how many glasses do you drink per week ?		Do you use a water filter, or drink bottled water instead of tap water ?	
How many packets of 'instant' or 'fast' foods do you eat each week ?		Do you frequently eat under stressed conditions or on-the-move ?	
How many cans of food do you eat in a typical week ?		Does your job involve eating out a lot ?	
How many times per week do you have meals containing fried food ?		How would you describe your appetite ? <i>(eg poor, average, good, etc)</i>	

Please write down the food and drink you might consume in a 'typical' day, indicating where possible whether the food is fresh, unprocessed, or from a can or box:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks and drinks: _____

Nutritional Supplements: (if any) _____
