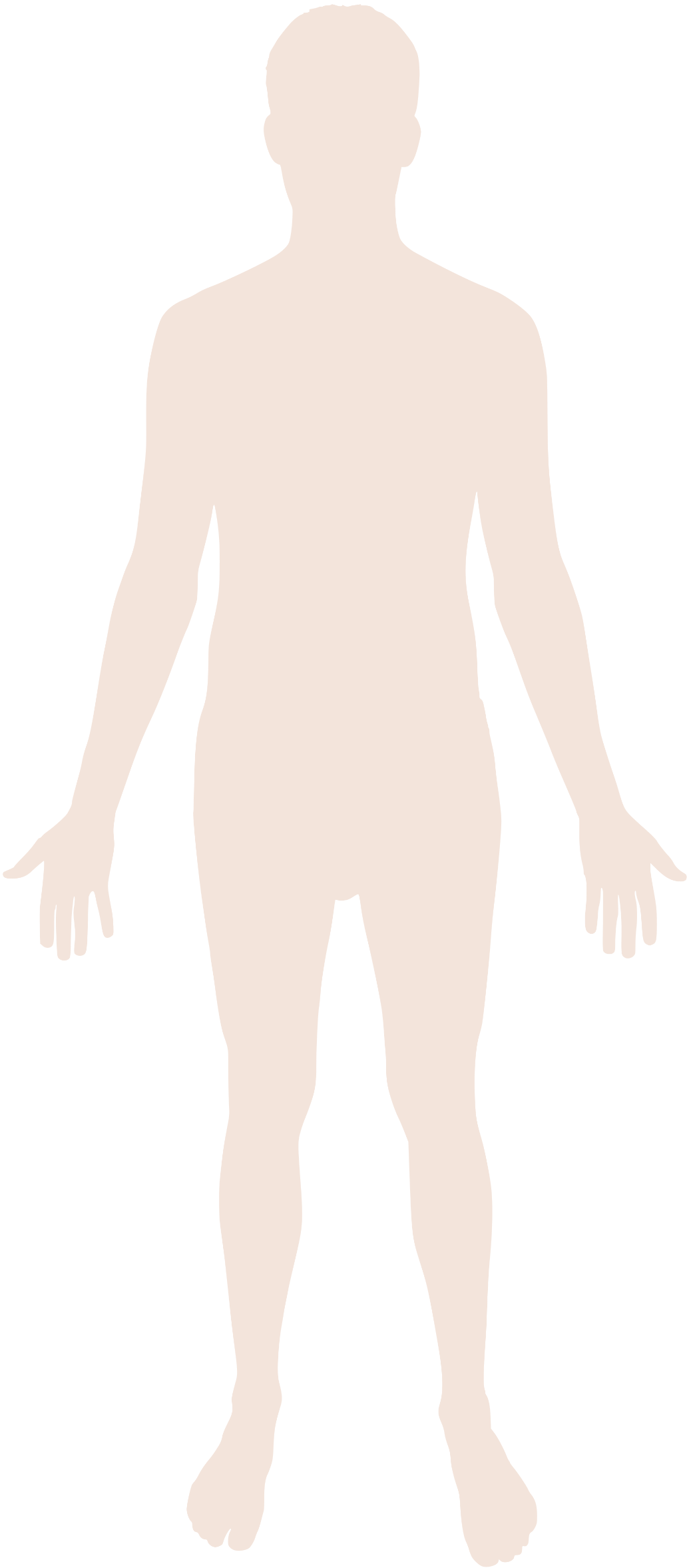
**Health Assessment Questionnaire**

**\*All details provided in this questionnaire will be held private and confidential as outlined in the data protection policy and according to GDPR regulations**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Title** |  | **First name** | | | | **Last name** | | | | | **Date of birth** | | **Age** |
| **Gender** |  |  | | | |  | | | | |  | |  |
| **Address** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | | | | | | | | | |
| **Post Code** |  | **E-mail** | | | | **Phone number/s Mobile:** | | | | | **Home: Work:** | | |
| **Marital status** | | | | | **No. of dependants** |  | | | **Age/sex of children** | | | | |
| **Height** |  | **Waist measurement** | | |  | | | |
| **Weight** |  | **Hip measurement** | | |  | | | |
| **GP’s details** | | | | | | | | | | | | | |
| **Doctors Name** | | | |  | | | | | |  | | | |
| **Surgery address** | | | |  | | | | | |  | | | |
| **Surgery telephone number** | | | |  | | | | | |  | | | |
| **Do you give permission for your medical doctor to be contacted? (tick box)** | | | | **Yes** | | | | **No** | |  | | | |
| **Is your doctor aware of your intention to seek dietary assistance?** | | | |  | | | | | |  | | | |
| **Prescription medications and supplements (including the contraceptive pill) Name of medication** | | | **Dosage** | | | | **Duration** | | | | | **Please tick past or present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
|  | | |  | | | |  | | | | | **Past Present** | |
| **Reason for seeking nutritional advice** | | | | | | | | | | | | | |
| **What are your main health goals or priorities** | | | | | | | | | | | | | |
| **Name two symptoms you would most like to address and rate how bad they are them from 1 to 10 (1 being good and 10 bad)** | | | | | | | | | | | | | |
|  | | | | **Symptom** | | | | | | **Rating** | | | |
| **Symptom one** | | | |  | | | | | |  | | | |
| **Symptom two** | | | |  | | | | | |  | | | |
| **Symptom three** | | | |  | | | | | |  | | | |
| **What sort of support have you already received or tried e.g. GP, consultant, dietician, psychologist, weight loss groups, complementary therapies – (please give details)?** | | | |  | | | | | | | | | |
| **Are you currently undergoing or waiting to begin medical treatment? (if so please give details)** | | | |  | | | | | | | | | |
| **Are you currently pregnant or aiming to become pregnant?** | | | |  | | | | | | | | | |
| **Do you have any allergies or intolerances? (please give details)** | | | |  | | | | | | | | | |

**Body Scan** (please select any symptoms you may have by ticking/selecting the appropriate box) (tick all that you have experienced to date and underline those that are relevant now

**Head Mood**

headachesmigrainestiff neck fuzzy headeddizziness depressedanxioustenseangryhappy  
poor balancepounding headfeeling of hangoverunexplained pain balancedoptimisticsadpessimistic  
 tiredcan’t be botheredhyperactive  
**Hair** cheerfulagitatedeasily upsettearful  
oily dry poor conditionbrittlethinning jitteryfrightenedexplosivepent up   
Prematurely greydandruffincreased facial hair irritatedannoyedoverwhelmedsuicidal  
increased body hairdecreased body hair fluctuatingaggressive

**Mouth Mind**Sore tonguewhite/red patchestooth decayulcers forgetfuldifficulty learning new things  
bad breathsore throatspoor sense of tasteexcess saliva easily confusedcan’t switch off  
dry mouth difficulty swallowinghoarse voicegingivitis difficulty concentratingeasily frustrated  
bleeding gumscold sores easily distracteddifficult to make decisions   
 loss of interest in daily lifefogginess  
**Eyes** dyslexiadyspraxiainsomniahyperactive  
burninggrittyprotrudingprone to infectionstickyitchy panic attacksno motivation  
painfulpoor night visiondrycataractssensitive to light  
bagsswollen eyelidsblurred visiondouble vision **Chest**  
failing eyesightyellow sclera (white of eye) frequent coldschest infectionsasthma  
 bronchitispalpitationsheart condition  
**Ears** chest discomfort/painshort of breath  
blockedsoreitchyweepingwateringoverly waxy difficulty breathingwheezing  
creased earlobe persistent coughnoisy breathing  
 breast pain  
**Nose**congestedrunnyfrequent nose bleedsprone to snoring **Gut**  
sinusitishay feverpost-nasal driprhinitissneezing bloatedpainfultendercramping  
poor sense of smell distendednauseahiatus hernia  
 sensation of fullnessacid reflux heartburn  
**Muscles** flatulencebelchingchurningvomiting  
tenderpaincrampsspasmstwitchesloss of tone irritable bowelcoeliacdiverticulapolyps  
wastingweakstiffrestless legsnumbness haemorrhoidsulcerssluggishsensitive  
 constipationdiarrhoea  
**Skin**   
dryroughflakyscalypuffypalebrown patches **Genitals**  
change in moles/lesionscongestedoilyclammyyellow itchythrushulcerswartsherpes  
slow to healacnepimplesrosaceaeczemadermatitis groin painprostatitis  
psoriasisrashesboilshivesstretch markscellulite pelvic inflammatory diseaseimpotence  
easy bruisingthread veinsvaricose veinsringworm painful intercoursevaginal dryness  
allergic reactionsexcessive sweating painful or frequent urination  
 unexplained discharge  
**Joints**   
painfulinflamedswollenstiffrheumaticarthritic **Hands**achingsoredifficulty bendingreduced mobilityunsteadiness drycrackedeczemapain in jointspuffy  
slow movement chilblainsnumbnesstinglingfeel clumsy  
 feel uncoordinatedpoor circulation  
**Nails**fragiledrybrittleflakypeelingsplitfungalhangnails **legs and feet**  
infectedsplit cuticlesridgedspoon shaped restless legsswollenachingathletes foot  
white spots on more than 2horizontal white linesthickened burning feettender heelsgoutsciatica  
dark nailspale nail bed cold feettinglingnumbprickling

**Diet** – please complete attached diet diary to the best of your ability (the more information I receive the better)

Are you currently following a medically prescribed diet (if so please give details)? Yes No

Do you have any food allergies or intolerances?

**Family history and health**

Is there any history of physical or mental health problems, symptoms or disease in your family? If so, please give details.

**Grandfathers:**Maternal:

Paternal:

**Grandmothers:**Maternal:

Paternal:

**Father:**

**Mother:**

**Siblings:** (indicate ages and whether full or half blood relatives)

**Children:** (indicate ages)

**Personal Health History**

Starting with your most current health problems please list in the space provided, all significant health problems that you have encountered in your lifetime. Indicate where appropriate, the duration, timing and management of the health problem.

|  |  |  |  |
| --- | --- | --- | --- |
| **Health Problem e.g. depression, asthma,** | **Duration** | **Management e.g. antidepressant; citalopram, Ventolin and wheat free diet** | **Date i.e. 1980-current** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Additional questions:**

On average how much sleep do you get per night?

Do you have any history of eating disorders, substance abuse, high stress levels, psychiatric or neurological disorders that you have not yet mentioned? If so, please expand on these.

Do you have any difficulties maintaining dietary changes e.g. cravings, binging, emotional eating, loss of interest in food?

Is there anything else that you haven’t mentioned yet which you think would be useful for me to be aware of? (if so please describe)

\* If you have been diagnosed or suspect you may have a medical condition, you should consult your GP for advice, diagnosis and treatment and always inform your health professional before starting any alternative or additional therapies, treatments or making any major changes in your diet or exercise programme.

\*This questionnaire has been adapted from ION, CNM and CNELM documents.