CONFIDENTIAL CLIENT QUESTIONNAIRE

Please provide details as fully and accurately as possible. If at any time you need more space please continue on a separate sheet

Maria Bray Nutritional Therapy

TITLE _____ FIRST NAME _____ LAST NAME _____

DATE OF BIRTH _____ AGE _____

ADDRESS _____

POSTCODE _____ EMAIL _____

TEL: HOME: _____ WORK: _____ MOBILE: _____

OCCUPATION _____ WORK ENVIRONMENT (Eg. City. Rural) _____

Health Profile

What is your main reason for seeking nutritional advice? _____

What outcome are you hoping to achieve? _____

Please list the issues you would like to focus on. *Continue on a separate sheet if you need more space.*

Health issue (eg. psoriasis, overweight)	**Management so far** (eg. GP, operation, exercise, paracetemol etc.)	**Onset/duration**

Have you had any recent health tests? Please specify or attach, if appropriate

_____

_____

Have you had any other major surgery, biopsies, diagnosed medical conditions, and significant periods of ill health or do you suffer from any allergies, chronic or niggling health problems? (please give full details eg. high blood pressure, frequent colds, recurrent urinary infections etc.)

_____

Do you suspect your symptoms relate to a particular event of time in your life?_____

Medication & Remedies

Please list ***anything you take regularly*** including GP prescribed medication, self-prescribed medication (eg. painkillers, antacids) nutritional supplements, herbal or homeopathic remedies. Continue of a separate sheet if necessary.

Remedy	**Dose**	**Condition being treated**	**Frequency & Duration**	**Past/Current**
Antibiotic History: please note date and reasons you took antibiotics, in date order				

Body Scan

Please CIRCLE or UNDERLINE any conditions that you regularly experience.

Head

Headaches, migraine, stiff neck, fuzzy headed, *Dizziness,* poor-balance, pounding head, feeling hangover, *unexplained pain*

Hair

Oily, dry, poor condition, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decrease body hair

Mouth

Sore tongue, white/red patches, tooth decay, ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, *difficulty swallowing,* hoarse voice, gingivitis, bleeding gums, cold sores

Eyes

Burning, gritty, protruding, prone to infection, sticky, itchy, *painful,* poor night visions, dry, cataracts, sensitive to light, bags, swollen eyelids, ,*blurred vision,* double vision, failing eyesight, yellowish

Ears

Blocked, sore, itchy, weeping, watery, overly waxy, creased earlobe

Nose

Congested, runny, *frequent nose bleeds,* prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

Muscles

Tender, sore, cramps, spasms, twitches, loss of tone, wasting, *weak,* stiff, frozen, 'restless legs', numbness

Skin

Dry, rough, flaky, scaly, puffy, pale, brown patches, *change in moles or lesions,* prematurely lined, congested, oily, clammy, yellow, slow to heal

Skin prone to

Acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

Joints **(fingers, knees, back, shoulders, etc.)**

Painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

Mood

(please underline your predominant states - even if the conflict)
depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, irritated, annoyed, overwhelmed, *suicidal,* fluctuating, aggressive

Mind

forgetful, difficulty learning new things, easily confused, can't switch off, difficult concentrating, easily frustrated, easily distracted, difficult to make decisions, loss of interest in daily life, fogginess, dyslexia, dyspraxia, insomnia, hyperactive, panic attacks, no motivation

Chest

frequent colds and chest infections, asthma, bronchitis, palpitations, heart condition, *chest discomfort/pain, short of breath,* difficulty breathing, wheezing, *persistent cough,* noisy breathing, breast pain

Gut

bloated, *painful,* tender, cramping, distended, nausea, hiatus hernia, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, vomiting, irritable bowel, coeliac, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, *constipation, diarrhoea*

Genitals

itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, *painful or frequent urination,* unexplained discharge

Hands

dry, cracked, eczema, sore joints, puffy, cold, chilblains, *numbness,* tingling, feel clumsy & uncoordinated, poor circulation

Nails

fragile, dry, brittle, flaky, peeling, split, fungal, hangnails, infected, split cuticles, ridged, spoon shaped, white spots on more than 2, horizontal white lines, thickened or 'horny', dark nails, pale nail bed

Legs & Feet

restless legs, swollen, aching, athlete's foot, burning feet, tender heels, gout, sciatica, cold feet, tingling, *numb,* prickling

Important Symptoms:

Please indicate by underlining/highlighting if you suffer from any of the following symptoms which may require additional medical care:

Persistent unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine, stools; breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash of weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy

Women only

_____ Are you planning for a baby or pregnant?
_____ Do you have periods? Regular/irregular
_____ Do you have painful periods?
_____ Are your periods heavy/normal/scant?
_____ Do you have regular well-woman check-ups?
_____ History of miscarriage?
_____ Any indication of osteoporosis?
_____ Been diagnosed with low/high thyroid?
_____ Do you experience breast pain/lumps?
_____ Do you, or have you had an IUD fitted/the pill
_____ Do you have endometriosis/PCOS/fibroids?
_____ Do you have excessive hair growth?
_____ Do you, or have you taken HRT/natural HRT?
_____ Do you experience hot flushes/night sweats?
_____ Are you happy with your current sex drive?

If you have had children:

_____ Experienced complications in labour?
_____ Experienced complications in pregnancy?
_____ Experienced fertility problems?
_____ Experienced normal deliveries?
_____ Are you currently breastfeeding?

Age of first period? _____ years old
Age of final period? _____ years old

Menstruating Women: Please indicate by underlining if you experience: pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches.
Other?_____

Menopausal Women: Please indicate by underlining if you experience: hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness.
Other?_____

Men Only *Do you experience any of the following?*

_____ Altered urine flow
_____ Enlarged prostate
_____ Fertility problems
_____ Impotence
_____ Low sperm count
_____ Low sperm motility
_____ Prostatitis
_____ Mood swings or depression
_____ Any known genital-urinary conditions

Your Vital Statistics

_____ what is your normal blood pressure?
_____ your resting pulse rate?
_____ your current weight?
_____ your height?
_____ your waist circumference? (if known)
_____ your hip circumference? (if known)
_____ your blood type? (if known)
_____ is your weight stable, increasing or decreasing?
_____ did you have the recommended childhood immunisations?

Your Energy Levels

_____ Do you need more than 8 hours sleep per night?
_____ Is your energy less than you want it to be?
_____ Do you find it difficult to get going In the morning?
_____ Do you feel drowsy in the day?
_____ What time(s) of day is your energy lowest?
_____ Do you get dizzy or irritable if you don't eat often?
_____ Do you use caffeine, sugar or nicotine to keep going?
_____ Do you find it difficult to concentrate?
_____ Do you feel dizzy or light-headed standing quickly?
_____ Do you suffer from unexplained fatigue or listlessness?

Your Daily Life

_____ Do you enjoy your daily life?
_____ How many people depend on your support?
_____ Do you feel supported by people around you?
_____ Are you recent separated/divorced/a new parent?
_____ Are you recently bereaved?
_____ Have you moved house or changed jobs recently?
_____ Do you work long or irregular hours?
_____ Is your workload bigger than you can manage?
_____ Are you under significant stress in any other way?
_____ Do you feel guilty when relaxing?
_____ Do you have a strong drive for achievement?
_____ Do you often do 2 or 3 tasks simultaneously?
_____ Do you take regular exercise?
_____ Is your job active?
_____ Do you have active hobbies?
_____ Do you sleep well?
_____ What do you do for relaxation?

Your Digestion

Do you regularly experience……

_____ Indigestion
_____ Indigestion after fatty food
_____ Bowel movement shortly after eating?
_____ Frequent stomach upsets or stomach pain?
_____ Nausea or vomiting?
_____ Pain between the shoulders or under the ribs?
_____ Constipation or hard-to-pass stools?
_____ Diarrhoea or 'urgency to go'?
_____ Blood or mucus in stools?
_____ Undigested food in stools?
_____ Generally inconsistent bowel movements?
_____ Anal itching?
_____ Thrush or cystitis
_____ How often do you have a bowel movement?
_____ Have you noticed any recent change in bowel habit?
_____ Are your stools pale, mid brown, dark brown, black, grey?

_____ Have you ever had stomach upset after foreign travel?
_____ Do any foods cause digestive problems?_____

Dietary analysis

_____ Were you breast fed ?
_____Were you raised on a healthy diet?

List any foods that you crave _____
_____
What are your favourite foods?_____
_____
_____
What (if any) foods do you dislike? _____
_____
What foods would you find hard to give up?_____

_____

Do you prepare your own meals? _____

Do you enjoy cooking? _____

Do you have cereal for breakfast? If yes, which ones?_____

_____

Do you eat mainly wholegrain bread/pasta/rice or white? _____

_____

Do you add sugar to your food/drinks? _____

Do you add salt? _____

What type of spreads do you use? (e.g. butter/margarine)_____

_____

What sort of oil do you cook with? _____

_____

Do you use condiments and sauces? If so which ones?_____

_____

Do you use a microwave? If so how often? _____

_____

Do you ever eat organic foods? If so what?_____

_____

_____

Are you following a special diet for health or cultural reasons? Now or in the past? Please describe _____

_____

_____

Please complete the following table in respect of your current food intake:

FOOD/DRINK CONSUMED	PORTIONS/CUPS/ UNITS PER DAY OR WEEK	FOOD/ DRINK CONSUMED	PORTIONS/CUPS/UNITS PER DAY OR WEEK
Wheat		Ready Meals	
Dairy		Fruit	
Tea		Vegetables	
Coffee		Beans Or Pulses	
Alcohol		Salads	
Cakes		Pastries	
Poultry		Biscuits	
Eggs		Chocolate	
Red Meat		Fish (White And Oily)	
Other Confectionery		Take Away Meals	
Water (Tap, Filtered Or Bottled)		Food Past It's Use By Date	

Heredity profile

Age/sex of any children: _____ Age/sex of siblings: _____

Please indicate if any of the following occur in your family by ticking the appropriate box.

	MATERNAL SIDE	PATERNAL SIDE	SIBLINGS	CHILDREN	SELF
Addictive/Obsessive					
Alzheimer's Disease					
Heart & Circulation Problems					
Asthma					
Attention Deficit/					

Hyperactive/Learning Difficulties					
Autism					
Cancer					
Allergies/Sensitivities/Intolerances					
Chronic Fatigue					
Coeliac Disease					
Constipation					
Depression					
Diabetes (Type 1/Type11)					
Eczema					
Endometriosis					
Epilepsy					
Fibroids					
Hayfever					
Headaches/Migraines					
High Blood Pressure					
High Cholesterol					
Recurrent Infections					
Infertility/Miscarriages					
Insomnia					
Irritable Bowel					
Rheumatoid/Osteoarthritis					
Osteoporosis					
Thyroid Imbalance					
Overweight					
Parkinson's Disease					
Polycystic Ovaries					
Mood Disorders/Schizophrenia					
Other					

Please confirm if your parents and grandparents are alive and their current state of health:

Your Toxic Exposure

_____ Do you live, exercise or work in a city or by a busy road?
_____ Do you spend a lot of time on busy roads?
_____ Do you live close to an agricultural area?
_____ Do you drink unfiltered water?
_____ Do you drink alcohol? If so how many units per week?_____
_____ What is your normal alcoholic drink?
_____ Do you smoke? How many a day? _____
_____ Do you live in a smoky atmosphere?
_____ Do you think you may be addicted to anything?
_____ Do you spend a lot of time in front of a TV or VDU?
_____ Do you spend a lot of time on a mobile phone?
_____ Do you sunbathe a lot?
_____ Are you a frequent flyer?
_____ Are you exposed to chemicals through work or hobby?
_____ Do you heat, freeze or wrap food in plastic?
_____ Do you cook or wrap food in aluminium?
_____ Do you regularly take antacid (indigestion) medication?
_____ Do you frequently fry or roast foods at high temperatures?
_____ Do you regularly eat browned or barbequed foods?
_____ Do you regularly consume artificial sweetners?
_____ Do you floss your teeth regularly?
_____ Are your teeth filled with mercury amalgams?

Your Health carers

Is this your first visit to a Nutritional Therapist? _____

How did you find out about me? _____

GP details:

Name: _____

Address: _____

Telephone No: _____

Are there any other therapists/clinics involved in you care? Please list:

Name	Address	Purpose of care	Duration of care

Is there any information which you think is relevant and has not been covered in this health profile? If so, please add._____
_____
_____
_____
_____

I have disclosed all the relevant information applicable to this consultation and my health status at this point in time. I consent for the information provided to be used by my Nutritional Therapist and for my therapist to liaise with appropriate health professionals as is applicable and agreed.

Signed: _____ **Date of Signature:** _____