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Preferred pronouns: Select First Name: Last Name: Date of Birth:

Address:

Post Code: Email: Phone:

Which most accurately describes you? Select Occupation: Work environment (e.g. city, rural)

HEALTH PROFILE

What is your main reason for seeking nutritional advice?

What outcome are you hoping to achieve?

Please list the issue(s) you would like to focus on:

Health issue (e.g. arthritis, overweight)	Management so far (e.g. GP, operation, exercise, paracetamol etc.)	Onset / duration

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

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

MEDICATIONS AND REMEDIES please list anything you take regularly, including GP prescribed medication, self-prescribed medication (e.g. painkillers) nutritional supplements, herbal or homeopathic remedies.

Remedy	Dose	Condition being treated	Frequency and Duration
Antibiotic history: please state when and why you last took antibiotics, plus any previous time you can recall:			

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Please tick any symptoms you are experiencing under each of the body/mind areas:

Head

- ☐ Headaches*
- ☐ Migraine
- ☐ Stiff neck
- ☐ Fuzzy-headed
- ☐ Dizziness*
- ☐ Poor balance
- ☐ Pounding head
- ☐ Feeling of hangover
- ☐ Unexplained pain*

Hair

- ☐ Oily
- ☐ Dry
- ☐ Poor condition
- ☐ Brittle
- ☐ Thinning
- ☐ Prematurely grey
- ☐ Dandruff
- ☐ Increased facial hair
- ☐ Increased body hair
- ☐ Decreased 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
- ☐ Mouth-breathing

Eyes

- ☐ Burning
- ☐ Gritty
- ☐ Protruding
- ☐ Prone to infection
- ☐ Sticky
- ☐ Itchy
- ☐ Painful*
- ☐ Poor night vision
- ☐ 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 / 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

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Please tick any symptoms you are experiencing under each of the body/mind areas:

Mood (please tick your predominant states – even if they conflict)

- ☐ Depressed*
- ☐ Anxious
- ☐ Tense
- ☐ Angry
- ☐ Happy
- ☐ Balanced
- ☐ Optimistic
- ☐ Sad
- ☐ Pessimistic
- ☐ Tired
- ☐ Can't be bothered / apathetic
- ☐ Hyperactive
- ☐ Cheerful
- ☐ Agitated
- ☐ Easily upset
- ☐ Tearful
- ☐ Jittery
- ☐ Frightened
- ☐ Explosive
- ☐ Pent up
- ☐ Worried
- ☐ Irritated
- ☐ Annoyed
- ☐ Overwhelmed
- ☐ Suicidal thoughts*
- ☐ Fluctuating
- ☐ Aggressive

Mind

- ☐ Forgetful
- ☐ Difficulty learning new things
- ☐ Easily confused
- ☐ Can't switch off
- ☐ Difficulty concentrating
- ☐ Easily frustrated
- ☐ Easily distracted
- ☐ Difficulty making decisions
- ☐ Loss on interest in daily life*
- ☐ Fogginess
- ☐ Dyslexia
- ☐ Dyspraxia
- ☐ Insomnia
- ☐ Hyperactive
- ☐ Panic attacks
- ☐ Lack of motivation

Chest

- ☐ Frequent colds / chest infections
- ☐ Asthma
- ☐ Bronchitis
- ☐ Palpitations
- ☐ Heart condition
- ☐ Chest discomfort / pain*
- ☐ Shortness 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
- ☐ Diverticulitis
- ☐ Polyps
- ☐ Haemorrhoids
- ☐ Ulcer(s)
- ☐ 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
- ☐ Feeling clumsy
- ☐ Feeling uncoordinated
- ☐ Poor circulation

Nails

- ☐ Fragile
- ☐ Dry
- ☐ Brittle
- ☐ Flaky
- ☐ Peeling
- ☐ Split
- ☐ Fungal
- ☐ Hangnails
- ☐ Infected
- ☐ Split cuticles
- ☐ Ridged
- ☐ Spoon shaped
- ☐ White spots on more than two nails
- ☐ Horizontal white lines
- ☐ Thickened or 'horny'
- ☐ Dark nails
- ☐ Pale nail bed

Legs and Feet

- ☐ 'Restless legs'
- ☐ Swollen
- ☐ Aching
- ☐ Athlete's foot
- ☐ Burning feet
- ☐ Tender heels
- ☐ Gout
- ☐ Sciatica
- ☐ Cold feet
- ☐ Tingling
- ☐ Numb*
- ☐ Prickling

IMPORTANT SYMPTOMS:

Please check the box next to any of the following symptoms if they apply (please note these may require additional medical care):

☐ Persistent or 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 or weight loss ☐ Black or tarry stools ☐ Painless ulcers or fissures ☐ Bleeding in pregnancy

Please describe any significant symptoms not already noted (if any):

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Please provide the information below <u>if known</u>. If unknown, please leave blank

Your vital statistics

Please provide your:

- normal blood pressure
- resting pulse rate
- your weight
- your height
- your waist circumference
- your hip circumference
- your blood type

Is your weight stable, increasing or decreasing? Select

Did you have the recommended immunisations as a child? Select

Your family history

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc? Please state disease, age at onset, gender:

Grandparents

Parents

Siblings

Children

Your daily life

Do you enjoy your daily life?	Select
How many people depend on your support?	Select
Do you feel supported by people around you?	Select
Are you recently separated/divorced/a new parent?	Select
Are you recently bereaved?	Select
Have you moved house or changed jobs recently?	Select
Do you work long or irregular hours?	Select
Is your workload bigger than you can manage?	Select
Are you under significant stress in any other way?	Select
Do you feel guilty when you are relaxing?	Select

Your daily life cont.

Do you have a strong drive for achievement?	Select
Do you often do 2 or 3 tasks simultaneously?	Select
Do you take regular exercise?	Select
Is your job active?	Select
Do you have any active hobbies?	Select
Do you sleep well?	Select
What do you do for relaxation?	Select

Your digestion

Do you regularly experience:

Indigestion (after food or between meals)?	Select
Indigestions after fatty food?	Select
Bowel movement shortly after eating?	Select
Frequent stomach upsets or stomach pain?	Select
Nausea or vomiting?	Select
Pain between the shoulders or under the ribs?	Select
Constipation or hard-to-pass stools?	Select
Diarrhoea or 'urgency to go'?	Select
Blood or mucus in stools?	Select
Undigested food in stools?	Select
Generally inconsistent bowel movements?	Select
Anal itching?	Select
Thrush or cystitis?	Select

How often do you have a bowel movement?	Select
Have you noticed any recent change in bowel habit?	Select
Are your stools pale, mid-brown, dark brown, black, grey?	Select
Have you ever had a stomach upset after foreign travel?	Select
Do any foods cause digestive problems?	Select

Your toxic exposure

Do you live, exercise or work in a city or by a busy road?	Select
Do you spend a lot of time on busy roads?	Select
Do you live close to an agricultural area?	Select
Do you drink unfiltered water?	Select
Do you drink alcohol?	Select
If yes, how many units?	Select

1 unit = (approx.) 1 small (25ml) shot of spirit, ½ pint of lower strength beer, 2 thirds of a small (125ml) glass of wine

Your toxic exposure cont.

What is your usual alcoholic drink?

Do you smoke? Select

- If yes, how many per day? Select

Do you live in a smoky atmosphere? Select

Do you vape? Select

Do you think you may be addicted to anything? Select

Do you spend a lot of time in front of a screen? Select

Do you spend a lot of time on a mobile phone? Select

Do you sunbathe regularly? Select

Are you a frequent flyer? Select

Are you exposed to chemicals through work or a hobby? Select

Do you heat, freeze, or wrap food in aluminium? Select

Do you regularly take antacid (indigestion) medication? Select

Roughly what percentage of your food is organic? Select

Do you frequently fry or roast food at high temperatures? Select

Do you regularly eat browned or barbequed foods? Select

Do you eat oily fish or shellfish more than 3 x a week? Select

Do you regularly consume artificial sweeteners? Select

Do you floss your teeth regularly? Select

Are your teeth filled with mercury amalgams (fillings)? Select

Your energy levels

Do you need more than 8 hours sleep per night? Select

Is your energy less than you want it to be? Select

Do you find it difficult to get going in the morning? Select

Do you feel drowsy during the day? Select

What time(s) of day is your energy lowest? Select

Do you get dizzy or irritable if you don't eat often? Select

Do you use caffeine, sugar or nicotine to keep going? Select

Do you find it difficult to concentrate? Select

Do you feel dizzy or light-headed if you stand up quickly? Select

Do you suffer from unexplained fatigue to listlessness? Select

Eating habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find hard to give up?

Do you cater for a special diet in the household? Select

Who does the cooking in your household? Select

Do you avoid any food for cultural/ethical reasons? Select

Are you allergic to any foods? Select

Do you suspect any foods don't agree with you? Select

Have you recently changed your diet? Select

Do you eat on the move/when stressed? Select

Do you ever have eating binges? Select

What do you binge on?

Have you ever suffered from disordered eating? Select

Do you chew your food thoroughly? Select

Are you excessively thirsty? Select

Your hormones

Please indicate if you experience any of the following:

- Mood swings ☐
- Depression ☐
- Loss of sex drive ☐
- Loss of motivation and drive ☐
- Known genito-urinary conditions ☐
- Fertility problems ☐
- Problems with achieving or maintaining an erection ☐
- Frequent or difficult urination ☐
- Prostate problems ☐
- Wake at night to urinate ☐
- Difficult to start or stop urine stream ☐
- Pain or burning when urinating ☐

Are you pregnant? Select

- If yes, how many weeks?

Are you trying to become pregnant? Select

Are you breast-feeding at present? Select

How many children have you given birth to? Select

Have you had problems with fertility? Select

Have you ever had a miscarriage? Select

What contraception do you use? Select

Are you still menstruating? Select

Are you or have you been on HRT? Select

Are your periods regular? Select

Any bleeding or spotting in between? Select

Are you periods particularly heavy or painful? Select

Do you suffer from PCOS, fibroids, endometriosis? Select

Any known genito-urinary conditions? Select

Are you happy with your sex drive? Select

If you have menstrual cycles

Please indicate if you experience any of the following:

- Pre-menstrual bloating ☐
- Tiredness ☐
- Irritability ☐
- Depression ☐
- Breast tenderness ☐
- Water retention ☐
- Headaches ☐
- Other ☐

If you are peri- or post-menopausal

Please indicate if you experience any of the following:

- Hot flushes ☐
- Insomnia ☐
- Osteoporosis ☐
- Mood swings ☐
- Depression ☐
- Vaginal dryness ☐
- Other ☐

DAILY ROUTINE

	Day 1	Day 2	Day off
Wake up time			
Get up time			
Work day start time			
Work day breaks (total hrs)			
Work day end time			
Time spent travelling			
Time spent exercising			
Type of exercise			
Exercise time of day			
Time spent relaxing			
Type of relaxation			
Other leisure activity			
Other routine			
Time spent outdoors			
Energy low times			
Overall mood			
Go to bed time			
Fall asleep time			
Uninterrupted sleep			

FOOD DIARY

Please choose 2 fairly typical weekdays and a weekend or day off and record as much as you can about your eating, beverages, sleep and leisure patterns in the form below.

If you prefer to upload photographs of your meals and beverages, please upload here

	Weekday 1	Weekday 2	Day off
Breakfast	Time:	Time:	Time:
Lunch	Time:	Time:	Time:
Dinner	Time:	Time:	Time:
Snack	Time:	Time:	Time:
Drinks	Coffees (sugars/cup) Black tea (sugar per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks	Coffees (sugars/cup) Black tea (sugar per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks	Coffees (sugars/cup) Black tea (sugar per cup) Green/herbal tea Fizzy drinks/cordial Units of alcohol Glasses of water Other drinks

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Your health carers

Is this your first visit to a Nutritional Therapist?

Select

How did you find out about me?

Select

GP Name:

GP Address:

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

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 for the purposes of my healthcare.

Signed Date