NUTRITIONAL HEALTH QUESTIONNAIRE

Salisbury Nutrition

This questionnaire is designed to provide the information required to create a personal healthy eating plan specifically tailored to your needs. **All information provided is treated in the strictest confidence**. Please answer the questions as fully as possible (using additional sheets if necessary) and return the completed questionnaire to sharon@salisburynutrition.co.uk at least **three days** before your appointment

Title		Name		DOB	
Address					
Email:		Tel:		Mobile	
Occupation		Marital Status			

Health Profile

What's your main reason for seeking nutritional advice?

Height	Weight		Is your weight stable increasing decreasing
BMI	Blood Pressure (if known)		

Which of these methods have you tried to manage your weight (gain or lose)?

Please tick all that apply		Did It Work
Dietitian/nutritionist		Yes/No
Exercise		Yes/No
Low calorie diet		Yes/No
Very low calorie diet (i.e. liquid, fasting)		Yes/No
Formal group program (i.e. Weightwatchers)		Yes/No
Prescription drugs		Yes/No
Over the counter diet drugs		Yes/No
Psychological counselling/behaviour modification		Yes/No
Hypnosis		Yes/No
Have you ever induced vomiting or used laxatives for weight loss?		Yes/No
Have you engaged in excessive exercise to help you lose weight		Yes/No

If you did not maintain your weight change for at least 1 year, why do you think you were not successful

Do family members struggle with being overweight? *(tick all that apply)*

Mother		Father		Sister		Brother	

Family History		
How many children do you have?	Number	Ages
Daughters		
Sons		

Do you have a family history of disease or allergies (e.g. heart disease, diabetes, asthma)? State disease, age at onset & gender			
	Illness/Allergy	Age of Onset	Male/Female
Grandparents			
Parents			
Siblings			
Children			

Your Vital Statistics	
What is your normal blood pressure	
Resting pulse rate	
Current weight	
Height	
Waist circumference (if known)	
Hip circumference (if known)	

Lifestyle			
Do you enjoy your daily Life	Yes/No	Do you work long irregular hours	Yes/No
How many people depend on you for support		Are you under any significant stress	Yes/No
Do you feel supported by the people around you	Yes/No	Is your job/daily life active	Yes/No
Are you recently bereaved/separated/divorced	Yes/No	Do you smoke? If so how many per day	
Have you moved house or changed jobs recently	Yes/No	Do you think you may be addicted to anything	Yes/No

Please rate the following using the scale below: How stressed have you been in the last month? LOW STRESS 1 2 3 4 5 6 7 8 9 10 HIGH STRESS How motivated are you to change your diet/lifestyle? HIGH MOTIVATION 1 2 3 4 5 6 7 8 9 10 LOW MOTIVATION
Do you take regular exercise if so what & when
What do you do for relaxation/hobbies?
What time do you usually go to sleep/awake?
Do you have problems sleeping? If so please state

Eating Habits

What are your favourite foods?
Are there any foods that you dislike?
Do you avoid any foods for cultural/ethical reasons? If so, which ones
Are you sensitive/**allergic** to any foods, if so, which ones
Are there any foods you crave and would find it difficult to live without?
Do any foods cause digestive problems? If so, which ones
Do you ever have eating binges, if so what do you binge on
Who does the cooking in your household?
Do you regularly eat organic □ fruit □ vegetables
What kind of bread, rice & pasta do you usually eat? Bread: □ White □ Brown □ Wholemeal □ Granary Pasta: □ White □ Wholemeal Rice: □ White □ Brown □ Wild

Do you eat on the move/when stressed	Yes/No		Do you use salt in cooking/add it to your food?	Yes/No
Do you eat at regular times each day	Yes/No		Do you add sugar to your hot drinks? If yes, how many spoons per cup	
Do you regularly miss meals?	Yes/No		Do you enjoy cooking/food preparation	Yes/No
Do you eat when you're upset or nervous	Yes/No		Do you regularly eat with family/friends	Yes/No
Eat in front of the TV or computer	Yes/No		Eat sweets or salty snacks	Yes/No

Please tick the frequency of the foods you regularly eat

Meal	How often do you eat
Breakfast	Daily Most morning 2-3 times a week Seldom or never
Snacks	3 or more a day 1-2 a day Few times a week Seldom or never
Fatty Foods	4 or more a week 2-3 times per week 2-4 times a month Seldom or never
Vegetables & Fruits	5 or more a day 204 a day 1-2 a month Seldom or never
Takeaways/Fast Food	4 or more a week 2-3 times per week 2-4 times a month Seldom or never

How many times a week do you drink?
For alcohol consumption please state numbers of units consumed per week
(1 Unit = 1 small glass of wine, ½ pint Lager, Beer or Cider or 1 measure of spirits)

Red/White Wine			Beer/Lager/Cider	
Spirits			Canned Fizzy Drinks*	
Coffee			Tea	

*If Yes – please indicate brand(s) and whether full fat, low calorie below:

Which cooking methods do you generally use?
□Boiling □ Steaming □ Grilling □ Deep Fry □Shallow Fry □Baking □ Roasting □Microwave

Physical Activity	
What physical problems if any, limit physical activity?	

How much do you enjoy physical activity		How Often do you take part in Exercise	
Not at all		6-7 times per week	
Moderately		3-5 times per week	
Greatly		1-2 times per week	
		A few times per month	

What Exercise do you enjoy & have participated in during the last 12 months	
Walking (outside or indoors)	
Yoga (Hatha, Vinyasa, heated)	
Jogging/running	
Group exercise classes	
Biking (outside or indoors)	
Exercise at home (DVD, Amazon Prime etc)	
Tennis	
Badminton	
Squash	
Swimming	
Golf	
Strength training	
Other:	

Intensity		Time Spent	
Aerobic activities that result in heavy breathing and sweating (e.g. high impact aerobics, running, speed swimming, distance cycling)		Over 30 minutes	
Moderate aerobic activity (e.g. normal bike riding, jogging, low impact aerobics)		30 minutes	
Light aerobic activity (e.g. normal walking, golf)		Under 30 minutes	

READINESS CHECKLIST

Who, if anyone is supportive of your decision to begin weight change efforts now?	What will you have to sacrifice? What are the down sides of changing your weight right now?

How important is it that you manage your weight at this time? Pick a number between 1 and 10 in which 1 = "not important" and 10 = "very important"	**How confident are you that you will be able to significantly change your eating and exercise habits?** Pick a number between 1 and 10 in which 1 = "not confident" and 10 = "very confident"
My number =	My number =

What are the benefits to you of weight change?	**How much time can you devote to this a day?**

If you decide to make the choice to live healthier, which of the following, if any, would work best for you?

Increased physical activity		Watch less TV	
Eat more fruit/vegetables		Spend less time on the computer	
Limit eating out/fast food		Eat less fat/fewer fatty foods	
Eat more whole grains/high fibre foods		Drink fewer sugar sweetened drinks	
Reduce calories/reduce portion size		Learn more about meal preparation	
Eat fewer deserts and sweet food		Get more involved in menu planning	

Tick the top 5 values that are the most important to you			
Authenticity		Excellence	
Balance		Faith	
Beauty		Family	
Career		Financial security	
Clarity		Fitness	
Compassion		Freedom	
Connection		Friends/Social Life	
Contribution		Generosity	
Courage		Good Attitude	
Education		Gratitude	
Enjoyment		Growth	
Energetic		Health	
Honesty		Humility	
Humour		Innovation	
Integrity		Joyfulness	
Leadership		Loyalty	
Parenting		Patience	
Perseverance		Playfulness	
Professionalism		Prosperity	
Purposefulness		Quality	
Respect		Responsibility	
Self-esteem		Spirituality/Religion	
Teamwork		Unconditional Love	

3 Day Food Diary

Please choose 2 fairly typical weekdays and a weekend/day off and record what you ate and drank. Please give as much information as possible, i.e. portion size, home cooked (state ingredients), shop brought, brand names, fresh, organic, wholegrain, whole-wheat, or white etc.

	Week Day 1		Week Day 2		Weekend/Day Off	
Breakfast	Time:		Time:		Time:	
Lunch	Time:		Time:		Time:	
Dinner	Time:		Time:		Time:	
Snacks	Time:		Time:		Time:	
Drinks	Coffee		Coffee		Coffee	
	Tea		Tea		Tea	
	Green/Herbal Tea		Green/Herbal Tea		Green/Herbal Tea	
	Fizzy Drinks/Cordial		Fizzy Drinks/Cordial		Fizzy Drinks/Cordial	
	Units of Alcohol Type:		Units of Alcohol Type:		Units of Alcohol Type:	
	Glasses of Water		Glasses of Water		Glasses of Water	
	Other Drinks		Other Drinks		Other Drinks	