

NUTRITIONAL HEALTH QUESTIONNAIRE



This questionnaire is designed to provide the information required to create a personal nutritional 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)				

Current Health Concerns (please list in order of concern and continue on a separate sheet if necessary)	Onset/Duration
1.	
2.	
3.	
4.	
5.	

Medication

Medication	Reason for Taking it/Condition?	How long have you been taking it?	Dose/Frequency
1.			
2.			
3.			
4.			
5.			

Have you ever taken antibiotics? If so when and for how long?

Supplements

Supplement & Brand	Reason for Taking it	How Long Have you been taking it	Dose/Frequency
1.			
2.			
3.			
4.			
5.			

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 <input type="checkbox"/> fruit <input type="checkbox"/> vegetables <input type="checkbox"/> meat <input type="checkbox"/> dairy
What kind of bread, rice & pasta do you usually eat? Bread: <input type="checkbox"/> White <input type="checkbox"/> Brown <input type="checkbox"/> Wholemeal <input type="checkbox"/> Granary Pasta: <input type="checkbox"/> White <input type="checkbox"/> Wholemeal Rice: <input type="checkbox"/> White <input type="checkbox"/> Brown <input type="checkbox"/> 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

How many times a week do you eat?

Red Meat (Beef, Lamb, Pork Game)			Chocolate/Sweets	
Processed Meats (Ham, Bacon, Sausages Hamburgers)			Puddings	
White Meat (Chicken/Turkey)			Cakes/Biscuits	
White Fish (Cod, Haddock, Pollock)			Ready Meals	
Oily Fish (Salmon, Trout, Herring Tuna, Mackerel)			Take Away/Fast Food	

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

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