NUTRITION FOR THE MENOPAUSE QUESTIONNAIRE

Salisbury Nutrition

This questionnaire is designed to provide the information required to create a personal nutritional & lifestyle 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 are the main concerns or questions you would like to address during your consultation?

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

Current Health Concerns (please list in order of concern ad 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

Your Digestion

Do you regularly experience any of the following?

Indigestion (after food or between meals)	
Indigestion after fatty food	
Bowel movement shortly after eating	
Frequent stomach upsets or stomach pain	
Nausea or vomiting	
Pain in 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	
General inconsistent bowel movements	
Anal itching	
Thrush or cystitis	
How many bowel movements do you have in 24 hours	
Have you noticed any recent change in bowel habit	
Have you ever had an upset stomach after foreign travel	
Do any foods cause digestive problems? Which ones?	

Your Toxic Exposure	
Do you live, work or exercise in the 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 usual alcoholic drink?	
Do you smoke? If so, how many per day?	
Do you live in a smoky atmosphere?	
Do you think you might be addicted to anything?	
Do you spend a lot of time in front of a TV, Computer or VDU?	
Do you spend a lot of time on a mobile phone?	
Do you regularly sunbathe?	
Are you a frequent flyer?	
Are you exposed to chemicals through work or hobby?	
Do you heat, freeze or wrap food in aluminium?	
Do you regularly take antacid (indigestion) medication?	
Roughly what percentage of your food is organic?	
Do you frequently fry or roast foods at high temperatures?	
Do you regularly eat brown or barbecued foods?	
Do you eat oily fish or shellfish more than 3 times a week?	
Do you regularly consume artificial sweeteners?	
Do you floss your teeth regularly?	
Are your teeth filled with mercury amalgams?	
Do you heat, freeze or wrap foods in plastics?	

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 during 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 if you stand up quickly?	
Do you suffer from unexplained fatigue or listlessness?	

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 □ meat □ dairy
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

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 (Salon, 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	
Water				

Which cooking methods do you generally use?

□Boiling □ Steaming □ Grilling □ Deep Fry □Shallow Fry □Baking □ Roasting □Microwave

Symptoms Please indicate any symptoms you suffer from and the frequency:				
	Not at all	A little	Quite a lot	Extremely
Hot flushes				
Night sweats				
Difficulty getting to sleep				
Heart palpitations				
Itchy/crawling skin				
Tiredness				
Difficulty concentrating				
Poor memory				
Irritability				
Anxiety				
Depression				
Mood swings				
Crying spells				
Headaches				
Need to urinate more frequently				
Pain or burning when urinating				
Bladder infections				
Dry vagina				
Vaginal itching				
Abnormal virginal discharge				
Vaginal infections				
Experience pain during intercourse				
Bleeding after intercourse				
Lack interest in sex				
Stomach feels like it is bloated or I have gained weight				
Breast tenderness				
Joint pains				

About Menopause & Hormone Therapy

Are you using HRT for the menopause	Yes		No	

How do you view the menopause					
Positively		Negatively		Other	
What concerns you about the menopause?					

How would you rate your knowledge of the menopause?							
Very Good		Fair		Moderately Good		Little Knowledge	

How do you get information about the menopause – tick all that apply											
Books		Internet		Magazines		Friends		TV		Other	

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	

Your Routine

Please do the same as for the three day food diary

	Day 1	Day 2	Day Off/Weekend
Wake up time			
Get up time			
Work day start time			
Work day breaks (total hours)			
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 routines			
Energy low time			
Overall mood			
Go to bed time			
Fall asleep time			
Uninterrupted sleep	Yes/No	Yes/No	Yes/No

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