

Oliver Barnett Nutrition questionnaire

Personal Details:

Date:

Name:Date of Birth:

Address:

.....

Telephone number/s:

E-mail address:

Sex:Marital status:Children:

Occupation:

Height:Weight:

Referred by:

General Practitioner's Details:

Name:

Address:.....

Tel. Number:

By Signing below I confirm that the information given to the practitioner is true and accurate. I also consent for information to be shared, when appropriate with my general practitioner.

Signed

Date:

Current Health and Medical History:

What is your main health condition/reason(s) for seeking nutritional advice?

Have you seen your doctor/GP about this health condition Yes No

Are you currently seeing any other health professionals/therapists about your health condition (please list)?

Please list any other current health conditions/concerns:

Has anything relieved any of these conditions?

Does anything aggravate any of these conditions?

Please list all prescription and over the counter medications you take on a regular basis:

Name	Dosage	How Often	For how Long	Any side effects?	Reason for taking

Please list all supplements you are currently taking:

Name/Brand	Dosage	How Often	For how Long	Any side effects	Reason For Taking

Have you had any recent health tests? If yes, please list with results if appropriate:

Please list all major illnesses/injuries you have had in the past:

Please list approximate hospitalisation dates and reason for hospitalisation:

Do you have any children? Yes No

If yes, please state age and sex:

Family medical problems

Do you suffer from any allergies or intolerances?

(foods, drugs & environmental)

Lifestyle profile**Exercise**

Do you currently exercise? Yes No

What type of exercise/sport do you do?

How many times per week (total?) 1 2 3 4 5+

For how many minutes per session? <15 15-30 30-45 45-60 60+

Sleep

At what time do you usually go to bed?

At what time do you usually get up in the morning?

Do you wake refreshed? Yes No

Do you wake in the night ? Yes No

At what time (approximately)?

Do you know why?

Relaxation

What do you do for relaxation?

On a scale of 1 -10, (1=low) what are your stress levels like?

Using the same scale what are energy levels like?

Cigarettes, Alcohol and Drugs

Have you ever smoked cigarettes/cigars Yes No

At what age did you start smoking?

How many cigarettes do you currently smoke each day?

If you have stopped smoking, at what age did you stop?

Do you drink alcohol? Yes No

On how many days per week (approximately)?

How many glasses would you normally drink per day?

At what time of day would you normally have a drink?

Do you use recreational drugs? If so, which?

Dietary Profile:

How many glasses (or litres/pints) of water do you drink daily?

How many cups of coffee do you drink daily?

How many cups of tea do you drink daily?

Do you have any dietary restrictions (e.g. vegetarian, vegan, dairy free)?

Do you add sugar to drinks? Yes No

Do you add salt when you cook? Yes No

Do you add salt at the table? Yes No

How many times a week do you eat the following:

Sugary foods, (chocolate/cake/sweets/biscuits)

Ready Meals

refined grains, (white pasta, rice, bread)

Take away

fizzy drinks

At restaurants

Fried foods

Cheese

Seeds/nuts

Red meat

Oily fish, (salmon mackerel, herring tuna)

Eggs

beans, lentils tofu

How many pieces of fruit do you eat each day?

How many different types of vegetable do you eat each day?

How many times a week do you eat salad?

Do you often eat on the move or at your desk?

What % of your diet is organic?

What foods do you crave?

What foods and drinks would be hardest to give up?

Describe usual daily foods

Review of systems – Have you ever suffered from any of the following:**Cardiovascular**

Chest Pain

Shortness of breath

Palpitations

Oedema

Varicose Veins

Cold Extremities/poor circulation

High/low Blood Pressure

Easy bruising or bleeding/poor wound healing

High Cholesterol

Musculoskeletal

Joint Pain/Stiffness (is this relieved through exercise or made worse)

Joint Swelling

Back/Neck Pain

Injuries

Spasms/cramps

Reduced range of movement

Bursitis

Arthritis

Skin

Acne/Dry/Oily	Hair loss
Eczema/Psoriasis	dandruff
Rashes	fungal infections
changes in hair condition	white marks on fingernails
Any of : Dry, brittle, ridged, flaky, splitting nails	Dermatitis

Nervous System

Anxiety/stress
 Pins & needles
 Mood swings
 Poor Memory/concentration
 Headache/Migraine
 dizziness

Gastrointestinal

Do you chew your food thoroughly before swallowing?

Do you find it hard to digest fatty foods?

Are you prone to stomach upsets?

Do you suffer from stomach cramps or pains?

Do you suffer from belching or heartburn?

Do you suffer from flatulence?

Do you suffer from bloating?

Do you suffer with constipation?

Do you strain to pass your stools?

Do you suffer with diarrhoea?

Do you ever have blood in your stools?

Do you have a good appetite?

Do you suffer from nausea or vomiting?

Do you suffer from haemorrhoids?

Do you have a bowel movement every day?

Can you please describe the colour & consistency?

Are you prone to significant weight changes?

Immune, Allergy & Intolerance profile

To your knowledge do you have any allergies/intolerances and if so, what?

If yes, what type of reaction?

Do you suffer from:

Stuffy or runny nose	Hay fever or excessive sneezing
Sinus problems	Asthma
Facial puffiness	Dark circles under the eyes
Itchy skin	Autoimmune disease (e.g. rheumatoid arthritis, lupus)
Frequent bloatedness	migraine

Were you vaccinated?

Have you travelled abroad recently?

Do you get more than 3 colds per year?

Do you find it hard to shift colds/infections?

Are you prone to thrush or cystitis?

Are you prone to mouth ulcers?

Do you suffer from cold sores?

Do you have an inflammatory condition (e.g. eczema, arthritis, hayfever)?

Slow wound healing?

Do you suffer from sore or bleeding gums?

Have you had a major personal loss in the last year or experienced chronic stress?

Do you live in a city or by a busy road?

Do you spend more than 2 hours per week in traffic?

Do you exercise (cycle, jog, walk) by busy roads?

Do you live or work in a smoky atmosphere?

Do you have any sensitivity to chemicals or smells?

Urinary system

How many times a day would you say you urinate?

Is there any urgency?

Do you ever experience any pain or burning?

Is there ever any blood in the urine?

Do you ever experience a weak stream or dribbling?

Does the urine have a strong odour?

Please describe the colour?

Endocrine

Do you experience any of the following?

Difficulty getting up

Unusual weight gain

Excessive hair loss

Hard to or guilty relaxing

Perspire excessively

Goitre

Poor temperature regulation

fatigue

unusual weight loss?

Reduced libido

easily angered

excessive thirst

Seasonal affected disorder (SAD)

Aversion to cold temperatures

Female Profile

At what age did your periods start?

Do you still have periods?

Have you suffered from amenorrhoea (loss of periods) in the past?

Are your periods regular?

Do you experience period pain?

Are your periods heavy? (Please include any clotting or colour information)

Have you experienced any loss of libido?

Do you experience any of the following PMS symptoms:

anxiety/tension/irritability/mood swings

Sweet cravings

low energy

Bloating

Depression

Headaches

Breast tenderness

Weight gain

Forgetfulness

Do you suffer from:

PCOS?

Endometriosis?

fibroids?

Breast cysts?

Have you experienced problems conceiving?

Are you using HRT?

Do you suffer from any of the following menopausal symptoms:

hot flushes

mood swings

insomnia

excessive sweating during the day

vaginal dryness

depression

night sweats

dry skin/hair

Are you post-menopausal? Yes No

Do you use the contraceptive pill/injection or IUD?

Are you pregnant? how many weeks?

Are you trying to become pregnant? Yes No

Declaration

I declare that the information provided is correct to the best of my knowledge and that I am not withholding any information which may be relevant.

Signed: _____ Date: _____