**Food for Life nutrition questionnaire**

Please complete as fully as possible. **CONFIDENTIAL**

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| Tel. (h): |
| Mob: |
| e-mail: |
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| **Name:****Address:** |

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| **Personal details.** |
| Height:Weight:Date of birth: | Resting pulse:Blood pressure:(if known). | Doctor’s name & address:Are they aware that you are visiting a Nutritional Therapist? Y/N? |
| Occupation: | Children or other dependants (Please give gender and age) |

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| **Goals & objectives:** |
| Reasons for / objectives in seeking nutritional advice: |

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| Please give name and details of any current diagnosed condition or disease?Was this diagnosed by a Doctor or Complimentary Health Practitioner ? (Please tick)If you are currently taking any medicine or pharmaceutical preparation, please give details? (Include name, dose and regularity of consumption.) |

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| **Medical History.** Please list any illnesses or operations (excluding colds or flu, unless persistent) starting from your childhood, to the present day. |
| Condition / illness /Operation | Age of Onset | Duration | Medication prescribed / taken? |
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| **Nutritional supplementation and complimentary therapies** |
| Do you take any nutritional supplements, herbal or homeopathic remedies (regularly or occasionally)? If so, please list including doses and manufacturers name.Have you ever visited a complimentary therapy practitioner (e.g. osteopath, acupuncturist, herbalist etc). Please give information re: dates and treatment, if known.  |

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| **Food choice and selection** |
| Are there any principles that guide your dietary choices e.g. local produce, religious guidelines, gluten free, low carbohydrate, dairy free, vegetarian, vegan, avoiding high GI foods? |
| Where would you shop for fresh food?  |
| Can you source organic foods?  | How often can you shop for fresh food?  | Do you grow any of your own food? | Do you like preparing food? |
| What food or meal would you choose as a treat? | What are your favourite foods and snacks? |
| Are there any foods and drinks that you avoid? |