

Nutritional Profile Questionnaire

Please print this document and send it, completed, with a cheque for £50 (UK pounds Sterling) to:

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Nutrition 4 All

34 Kynaston Wood, Harrow, HA3 6UA, United Kingdom

Your results will be returned within 7 days.

Private and Confidential

This questionnaire is designed to provide your nutritionist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First Name: _____ Last Name: _____

Address: _____

_____ Post Code: _____

Telephone Number:(Work) _____ (Home) _____

Occupation: _____ Date of Birth: _____

What is your Weight (without clothes): _____ Stone _____ lbs or _____ kg

What is your Height (without shoes): _____ feet _____ inches or _____ cm

Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems eg: Headaches 5 years (Continue on a separate sheet if you need more space)

Health problem

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

What medications (drugs) do you take for these? State daily dose _____

Under what circumstances do these problems improve? _____

Under what circumstances do they get worse? _____

What other illness have you had in the past ten years? _____

What operations have you had? _____

What is your normal blood pressure? _____ What is your blood group? _____

(Don't worry if you don't know either)

What is your resting pulse rate per minute? _____

(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

Heredity Profile

Do you have any children? If so, state age and sex. _____

How many brothers and sisters do you have? State age and sex. _____

Are there any particular illnesses that they suffer from? _____

What illness is/was your father prone to? _____

What illness is/was your mother prone to? _____

Symptom Analysis

Each question in this section starts with a list of symptoms associated with nutritional deficiency. Tick the box by the conditions you often suffer from. Some symptoms are repeated. Please underline them in all cases.

Don't worry if you don't have a colour printer - my system can handle black & white replies!

- Lack of energy
- Diarrhoea
- Insomnia
- Headaches or migraines
- Poor memory
- Anxiety or tension
- Depression
- Irritability
- Bleeding or tender gums
- Acne
- Muscle tremors or cramps
- Apathy
- Poor Concentration
- **Burning feet or tender heels**
- Nausea or vomiting
- **Dry, rough skin**
- Dry eyes
- Frequent infections
- Poor memory
- Loss of hair or dandruff
- Excessive thirst
- Poor wound healing
- PMS or breast pain
- Infertility
- **Muscle cramps or tremors**
- **Insomnia or nervousness**
- **Joint pain or arthritis**
- **Tooth decay**
- **High blood pressure**

- Lack of energy
- Exhaustion after light exercise
- Anxiety or tension
- Teeth grinding
- **Mouth ulcers**
- Infrequent dream recall
- **Muscle tremors or spasms**
- Poor night vision
- **Water retention**
- Muscle weakness
- Acne
- Tingling hands
- Insomnia or nervousness
- **Frequent colds or infections**
- Depression or nervousness
- High blood pressure
- Dry flaky skin
- Irritability
- Irregular heart beat
- Dandruff
- Muscle tremors or cramps
- Constipation
- Thrush or cystitis
- **Lack of energy**
- Fits or convulsions
- Diarrhoea
- Flaky skin
- Hyperactivity
- Depression
- **Rheumatism or arthritis**
- Poor hair condition
- **Pale skin**
- Bach ache
- Eczema or dermatitis
- **Sore tongue**
- Tooth decay
- Mouth over sensitive to hot or cold
- **Fatigue or listlessness**
- Hair loss
- Irritability
- **Loss of appetite or nausea**
- Excessive sweating
- Anxiety or tension
- **Heavy periods or blood loss**
- Muscle cramps or spasms
- **Lack of energy**
- Constipation
- Tender or sore muscles
- **Joint pain or stiffness**
- Pale skin
- Lack of energy
- Eczema
- Poor sense of taste or smell
- Lack of sex drive
- Cracked lips
- **Exhaustion after light exercise**
- Prematurely greying hair
- **White marks on more than two finger nails**
- **Easy bruising**
- Anxiety or tension
- Frequent infections
- **Slow wound healing**
- Poor memory
- Stretch marks
- Varicose veins
- **Lack of energy**
- Acne or greasy skin

- Loss of muscle tone
- Infertility
- **Frequent colds**
- Lack of energy
- **Frequent infections**
- Bleeding or tender gums
- Easy bruising
- Nose bleeds
- Slow wound healing
- Red pimples on skin
- Tender muscles
- Eye pains
- Irritability
- Poor concentration
- 'Prickly legs'
- Poor memory
- Stomach pains
- Constipation
- Tingling hands
- Rapid heart beat
- **Burning or gritty eyes**
- **Sensitivity to bright lights**
- Sore tongue
- Cataracts
- Dull or oily hair
- Eczema or dermatitis
- Split nails
- Poor appetite
- Stomach pains
- Depression
- **Dry skin**
- Poor hair condition
- Prematurely greying hair
- **Tender or sore muscles**
- **Poor appetite or nausea**
- **Eczema or dermatitis**
- Low fertility
- Pale skin
- Tendency to depression
- Poor appetite
- **Muscle twitches**
- **Childhood 'growing pains'**
- **Dizziness or poor sense of balance**
- **Fits or convulsions**
- **Sore knees**
- **Family history of cancer**
- **Signs of premature ageing**
- **Cataracts**
- **High blood pressure**
- **Frequent infections**
- **Excessive or cold sweats**
- **Dizzy/irritable after 6 hours without food**
- Need for frequent meals
- Cold hands
- Need for excessive sleep or drowsy during the day
- Excessive thirst

- Cracked lips

- 'Addicted' to sweet foods
-

Cardiovascular Profile

- Is your blood pressure above 140/90?
 - Is your pulse after 15 minutes rest above 75?
 - Are you more than 14lbs (7kg) over your ideal weight?
 - Do you smoke?
 - How many cigarettes a day?
 - Do you do less than two hours exercise a week?
 - Do you eat more than one spoon of sugar a day?
 - Do you eat meat more than 5 times a week?
 - Do you usually add salt to your food?
 - Do you have more than two alcoholic drinks a day?
 - Is there a history of heart disease in your family?
-

Exercise Profile

- Do you take exercise that noticeably raises your heartbeat for 20 minutes more than 3 times a week?
 - Does your job involve vigorous activity?
 - Do you regularly play sport? (football, squash, etc)
 - Do you have any physically tiring hobbies? (gardening, etc)
 - Do you consider yourself fit?
-

Pollution Risk Profile

- Do you live in a city or by a busy road?
- Do you spend more than 2 hours a week in traffic?
- Do you exercise (job, cycle, play sports) by a busy road?
- How many cigarettes a day do you smoke?
- Do you live or work in a smoky atmosphere?
- Do you buy foods exposed to exhaust fumes?

- Do you generally eat non-organic produce?
 - Do you drink more than 1 unit or oz of alcohol a day? (1 glass of wine, 1 pint of beer, or 1 measure of spirits)
 - Do you spend a lot of time in front of a TV or VDU?
 - Do you usually drink unfiltered tap water?
 - Do you have many amalgam dental fillings? (About how many?)
-

Stress Profile

- Is your energy less now than it used to be?
 - Do you feel guilty when relaxing?
 - Do you have a persistent need for achievement?
 - Are you unclear about your goals in life?
 - Are you especially competitive?
 - Do you work harder than most people?
 - Do you easily become angry?
 - Do you often do 2 or 3 tasks simultaneously?
 - Do you get impatient if people or things hold you up?
 - Do you have difficulty getting to sleep?
-

Glucose Tolerance Profile

- Do you need more than 8 hours sleep a night?
- Are you rarely wide awake within 20 minutes of rising?
- Do you need something to get you going in the morning, such as a tea, coffee or cigarette?
- Do you have tea, coffee, sugar containing foods or drinks, or cigarettes at regular intervals during the day?
- Do you often feel drowsy during the day?
- Do you get dizzy or irritable if you don't eat often?
- Do you avoid exercise due to tiredness?
- Do you sweat a lot or get excessively thirsty?
- Do you sometimes lose concentration?
- Is your energy less now than it used to be?

Digestion Profile

- Do you chew your food thoroughly?
- Do you sometimes suffer from bad breath?
- Are you prone to stomach upsets?
- Do you often get a burning sensation in your stomach?
- Do you find it difficult digesting fatty foods?
- Do you occasionally use indigestion tablets?
- Do you suffer from flatulence or bloating?
- Do you experience anal irritation?
- Do you have a bowel movement daily?
- Do your stools float?

Immune Profile

- Do you get more than three colds a year?
- Do you find it hard to shift an infection (cold or otherwise)?
- Are you prone to thrush or cystitis?
- Do you often take antibiotics more than twice a year?
- Is there a history of cancer in your family?
- Have you ever had any growths or lumps biopsied?
- Do you have an inflammatory disease such as eczema, asthma or arthritis?
- Do you suffer from hayfever?
- Do you suffer from allergy problems?
- Have you had a major personal loss in the last year?

Histamine Profile

Underline the following that apply to you:

Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious by nature, fat or 'well covered', can tolerate pain.

Sleep less than 7 hours, strong sex drive, little body hair, family history of allergies, fast metabolism, 'morning person', long toes and fingers, tends towards depression, don't put on weight, poor tolerance of pain.

Allergy Profile

Do you suffer from any of the following? Please underline.

Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.

Do you have any allergies? _____ If so what? _____

State type of reaction. _____

Have they been tested? _____

How have they been tested?

What foods or drinks would you find hard to give up?

Additional Questions for Women Only

___ Are you pregnant? if so how many weeks? _____

___ Are you trying to become pregnant?

___ Have you ever had a miscarriage?

___ Do you have an IUD fitted, or use the birth control pill? State which _____

___ Are your periods regular?

___ Are you post-menopausal?

___ Pre-menstrual symptoms: bloatedness, tiredness, irritability, depression, breast tenderness, headaches (*Please underline*)

Diet Analysis

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

1. ___ Were you breast fed?
2. ___ Was a significant percentage of your diet as a child high in fatty foods and sugar?
3. ___ Do you go out of your way to avoid foods containing preservatives or additives?
4. ___ Do you avoid foods which contain sugar?
5. ___ How many teaspoons of sugar do you add to food/drinks each day?
6. ___ Do you use salt in your cooking?
7. ___ Do you add salt to your food?
8. ___ How many coffees do you drink each day?
9. ___ How many cups of tea do you drink each day?

10. ___ How many times a week do you have meals containing fried food?
11. ___ How many packets of 'instant' or fast foods do you eat each week?
12. ___ How many times a week do you eat chocolate or confectionery?
13. ___ What percentage of your diet is **raw** fruit and **raw** vegetables?
14. ___ Do you wash fruit and vegetables before eating?
15. ___ Do you normally eat white rice or flour?
16. ___ How many cans of food do you eat per week?
17. ___ How many slices of bread or rolls do you eat each week?
18. ___ How many pints of milk do you drink in a week?
19. ___ How many times a week do you eat red meat? (*beef, pork, lamb or game*)
20. ___ How many times a week do you eat white meat? (*poultry, fish*)
21. What is your usual alcoholic drink?_____
22. ___ How many glasses do you drink a week?
23. ___ How many times a week do you eat live yoghurt?
24. ___ Do you use a water filter or drink bottled water instead of tap water?
25. Please specify any special dietary regime (e.g. vegetarian, vegan etc) _____
26. ___ Do you frequently eat under stressful conditions or on the move?
27. ___ Does your job involve eating out a lot?
28. ___ How would you describe your appetite?
 1. Poor
 2. Average
 3. Good

Sample Diet

Write down all the foods and drinks consumed over the next two days, starting today. Please add as much information as possible including quantities eaten, brand names, and whether the food is fresh or packaged, refined or natural.

Please tell me what time (approximately) you eat each meal.

Day 1

Breakfast:

Time:

Lunch:

Time:

Dinner:

Time:

Snacks/Drinks:

Time:

Day 2

Breakfast:

Time:

Lunch:

Time:

Dinner:

Time:

Snacks/Drinks:

Time:

Are these two days representative of your usual eating habits? If not, what is a more usual day?

Breakfast:

Time:

Lunch:

Time:

Dinner:

Time:

Snacks/Drinks:

Time:

What Nutritional Supplements do you take daily on a regular basis and at what time of day?

Which of these (if any) were prescribed by your GP?

To avoid duplication, what have you tried previously to resolve your problems and what results did you find?

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