



thenutricentre

Nutritional Therapy Consultation Form

Nutritionist's name:

Store location:

Date of consultation:

Customer details

Name:

Date of birth:

Occupation:

Height:

Weight:

Phone number:

Email address:

Address:

Sex: M ☐ F ☐

Only for women

Are you currently pregnant? Y ☐ N ☐

Are you currently breastfeeding? Y ☐ N ☐

Please provide details of any medications prescribed by your doctor / consultant that you are currently taking:

Name of medication	Reason for prescription	How long have you been taking this medication?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Please provide details of any nutritional supplements or herbal medicines that you are currently taking:

Name of supplement / herb	Reason for use	How long have you been taking this supplement/herb?
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

What is the reason you are seeking nutritional support? Please only give a brief comment here as further information will be requested during your consultation.

Medical history

Please fill in below any current and previous medical conditions, with treatment you have had for them.

Medical condition, disease or diagnosis	Date and duration	Treatment for this condition - please list all medication and operations you may have had	Do you have any current symptoms or problems related to this condition? If so please give details.
Example: Depression	2009-2011	Citalopram medication	None
Example: Hypertension	2006: 1 year	Ramipril medication	Better after a year



General health questions

Family health

Smoking, alcohol and exercise

Do you smoke cigarettes? Yes ☐ No ☐ If so, how many per day?
How many per week?

Do you drink alcohol? Yes ☐ No ☐ If so, how many units (or pints/glasses)
per day or per week?

What type of alcohol do you most commonly drink?

Do you exercise or play sports? Please give details of the type of activity and number of hours per week.

Heart and cholesterol

Do you have any problems with your heart or blood pressure? If so, please give details.

Do you have high cholesterol? If so, please give your total cholesterol level if known.

Digestive system / gastrointestinal

Do you suffer from any of the following gastrointestinal conditions? Please tick any that apply - you can tick more than one box.

- | | |
|--|--|
| <input type="checkbox"/> IBS (irritable bowel syndrome) | <input type="checkbox"/> Yeast overgrowth |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Hiatus hernia |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Parasitic infection (worms etc.) |
| <input type="checkbox"/> Coeliac disease | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Gluten intolerance / sensitivity | <input type="checkbox"/> Crohn's disease |
| <input type="checkbox"/> Lactose intolerance / sensitivity | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Any other condition not covered here? |
| <input type="checkbox"/> Diarrhoea | If so, please state which. <input type="text"/> |

Do you suffer from any of the following gastrointestinal symptoms? Tick any that apply - you can tick more than one box.

- | | |
|--|--|
| <input type="checkbox"/> Flatulence (wind) | <input type="checkbox"/> Feeling like you cannot digest fatty meals easily |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Often feeling 'over-full' after meals |
| <input type="checkbox"/> Indigestion | <input type="checkbox"/> Itchy anus |
| <input type="checkbox"/> Constipation | |
| <input type="checkbox"/> Nausea after eating | |
| Any other symptom not covered here: <input type="text"/> | |

On average, how many bowel movements do you have per day?

Do you suffer from constipation?

Yes ☐ No ☐

Do you suffer from diarrhoea?

Yes ☐ No ☐

Ears, nose and eyes

Do you currently have any of the following? Tick any that apply - you can tick more than one box.

- | | |
|--|---|
| <input type="checkbox"/> A reduction in taste or smell | <input type="checkbox"/> Recurrent eye infections |
| <input type="checkbox"/> Loss of balance (e.g. labyrinthitis, vertigo) | <input type="checkbox"/> Recurrent ear infections |

Kidneys and bladder

- Do you suffer from water retention? Yes ☐ No ☐
- Do you have any problems with urination (over-frequent urination, slow emptying bladder or leaking / incontinence)? Yes ☐ No ☐
If so, please give brief details.
- Do you suffer from cystitis or interstitial cystitis? Yes ☐ No ☐
If so, please specify which and give brief details.

Immune system

- How many instances of colds or flu have you experienced in the last 12 months?
- How many instances of coughs / chest infections have you experienced in the last 12 months?
- Do you have any known problems with your immune system (e.g. an autoimmune condition)? Y ☐ N ☐
If so, please briefly state the problem.
- Do you find you get over normal everyday illness quickly? Yes ☐ No ☐
- Do you have any issues with your throat (constant sore throats, loss of voice etc.)? Yes ☐ No ☐
If so, please give brief details.
- Do you get cold sores regularly? Yes ☐ No ☐
- Have you ever had glandular fever? Yes ☐ No ☐
- Do you experience hay fever / seasonal allergies? Yes ☐ No ☐
- Do you or have you recently suffered from athlete's foot? Yes ☐ No ☐
- Have you ever suffered from adult shingles? Yes ☐ No ☐
If so, is it recurring? Yes ☐ No ☐
- If you have a cut or graze, do you find it heals quickly? Yes ☐ No ☐
- Do you have any issues with your respiratory tract (lungs, breathing) such as asthma or constant infections? Yes ☐ No ☐
If so, please give brief details.
- Do you experience a lot of mucus or find you have to clear your throat regularly? Yes ☐ No ☐
- Do you commonly experience bleeding gums? Yes ☐ No ☐
- How often have you had antibiotics in your life? Please tick the most appropriate number below.
Less than twice ☐ 3 to 6 times ☐ 7 to 10 times ☐ More than 10 times ☐

Nutrient status

- Are you suffering from anaemia or low iron levels, or are you currently taking iron supplements / medication to correct or prevent an iron deficiency? Yes ☐ No ☐
If so, please give brief details.
- Have you had your vitamin B12 levels recently checked? Yes ☐ No ☐
If so, what was the result?
- Have you had your vitamin D levels recently checked? Yes ☐ No ☐
If so, what was the result?
- Have you had your calcium levels recently checked? Yes ☐ No ☐
If so, what was the result?
- How much sun exposure do you get?
Please give details if you work outside or have recently been on a sunny holiday where you had sunlight onto your skin.

Weight

- Do you have any problems with your weight? Yes ☐ No ☐
If so, please give brief details.
- Would you like help managing your weight? Yes ☐ No ☐

Energy, sleep and stress

- Do you suffer from a thyroid condition or have any issues with your thyroid function? Yes ☐ No ☐
If so, give brief details.
- Do you have any known issues with your adrenal function? Yes ☐ No ☐
If so, give brief details.
- How would you rate your general energy level out of 10? (1 = very poor, 10 = excellent)
- Do you have any problems with your sleep? E.g. difficulty falling asleep, waking up and not being able to get back to sleep? Yes ☐ No ☐
Please describe briefly.
- How would you rate your average stress levels, out of 10? (1 = not at all stressed, 10 = highly stressed)

Blood sugar / cravings

- Do you crave carbohydrates, starchy foods or sweet foods? Yes ☐ No ☐
Please give brief details.
- Do you feel you cannot go without food for very long, or experience any of these symptoms if you haven't eaten for a while: headaches, nausea, mood swings, weakness? Yes ☐ No ☐
Please state which.

Muscles, joints and bones

Do you have any physical pain (e.g. back pain, knee pain)? Yes ☐ No ☐
If so, please indicate location(s) of the pain.

Do you have any of the following? Tick any that apply - you can tick more than one box.

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> Osteopaenia | <input type="checkbox"/> Joint pain / stiffness |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Anything else relating to your muscles, joints or bones? |
| <input type="checkbox"/> Arthritis | |

Dietary questions

- Do you have any food allergies or intolerances? Yes ☐ No ☐
Please give details if so.
- Do you avoid any foods for religious or ethical reasons? Yes ☐ No ☐
If so, which foods?
- What foods do you dislike?
- What are your favourite foods?
- Do you have any food cravings? Yes ☐ No ☐
If so, please indicate which foods you crave.
- What percentage of your meals are home-cooked / home-prepared? (approximately)
- Do you eat oily fish? Yes ☐ No ☐
If so, how often?

Mental well-being / memory and concentration

- Do you suffer from low moods or depression? Yes ☐ No ☐
If so, give brief details.
- Do you suffer from SAD (seasonal affective disorder)? Yes ☐ No ☐
- Do you suffer from any other mental health disorders (e.g. obsessive compulsive disorder)? Yes ☐ No ☐
If so, give brief details.
- Do you feel you have a good memory? Yes ☐ No ☐
- Do you feel you have good concentration? Yes ☐ No ☐
- Do you suffer from headaches or migraines? Yes ☐ No ☐
If so, how often?

Hair and skin

- Do you have any issues with your hair (e.g. dryness, hair loss, eyebrow loss)? Yes ☐ No ☐
If so, give brief details.
- Do you have any issues with your skin health (e.g. dry skin, eczema, or other skin conditions)? Yes ☐ No ☐
If so, give brief details.

Men

- Do you have any problems with your prostate? Yes ☐ No ☐
If so, give brief details.
- Do you have any known problems with fertility (e.g. low sperm count)? Yes ☐ No ☐
If so, give brief details.
- Do you have any other issues relating to male health? Yes ☐ No ☐
If so, give brief details.

Please add anything else you would like us to know about you which may be relevant.

Women's health questions

Please complete this section even if you are (or you suspect you are) entering the menopause, as some of the questions are still relevant for this time. If you have completely menopaused, please fill in the peri-menopause and menopause section of this questionnaire, below.

- What form of contraception do you currently use (if any)?
- Do you currently have periods? Yes ☐ No ☐
If no, give a reason (if you don't know, put 'not known').
- Are you currently taking any prescription hormone medication such as HRT or progesterone? Yes ☐ No ☐
If so, give details.
- Are you currently trying for a baby? Yes ☐ No ☐
If so, give details if you have been experiencing any difficulties in conceiving (including any miscarriages or ectopic pregnancies).
- If you have had any children, please give their ages.
- What is the average length of your cycle (e.g. 24 days)? days
- Do you experience irregular periods? Yes ☐ No ☐
If so, give brief details.
- Do you suffer from endometriosis? Yes ☐ No ☐
If so, give brief details.
- Do you suffer from fibroids? Yes ☐ No ☐
If so, give brief details.
- Do you suffer from polycystic ovary syndrome? Yes ☐ No ☐
If so, give brief details.
- Do you experience heavy bleeding? Yes ☐ No ☐
If so, give brief details.
- Do you experience painful periods? Yes ☐ No ☐
If so, give brief details.
- Do you experience vaginal thrush? Yes ☐ No ☐
If so, give brief details.
- Do you feel you have low libido? Yes ☐ No ☐

Perimenopausal and menopausal women health questions

Please complete this section if you are going through the menopause, or are experiencing symptoms of menopause either before or after your periods have stopped.

- When was your last period? Give details in days, months or years.
- Are you taking HRT or similar? Yes ☐ No ☐
- Have you been using (or have used) any specific supplements to help you with the menopause e.g. black cohosh, sage? Yes ☐ No ☐
If so, which?

If you are going through the menopause (or believe you may be) please tick if you are experiencing any of these symptoms. Tick all the boxes that are applicable.

- | | |
|---|---|
| <input type="checkbox"/> Hot flushes or feeling too warm | <input type="checkbox"/> Dry vagina |
| <input type="checkbox"/> Cold chills | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Increase in blood pressure (high blood pressure) | <input type="checkbox"/> Problems with urination (small amounts of urine leaking) |
| <input type="checkbox"/> Tiredness / fatigue | <input type="checkbox"/> Urinary incontinence |
| <input type="checkbox"/> Brain fog / poor concentration | <input type="checkbox"/> Hair loss on your eyebrows |
| <input type="checkbox"/> Forgetfulness (poor memory) | <input type="checkbox"/> Difficulty in falling asleep |
| <input type="checkbox"/> Feeling more irritable or angry | <input type="checkbox"/> Loss of sleep or waking at night |
| <input type="checkbox"/> Weight gain (all over body) | <input type="checkbox"/> Problems with your thyroid |
| <input type="checkbox"/> Weight gain only around the abdomen | <input type="checkbox"/> Thinning hair or hair loss (on head) |
| <input type="checkbox"/> Dry skin | |

Please use this box if you want to give any further information about your peri-menopause or menopause experience or symptoms.

Here is a list of common pre-menstrual complaints (before your period starts).

Tick any that apply - you can tick more than one box.

- | | |
|---|---|
| <input type="checkbox"/> Feeling tearful / emotional | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> Mood swings / getting easily annoyed or frustrated | <input type="checkbox"/> Bloating or feeling as though you have gained weight |
| <input type="checkbox"/> Feeling especially tired | <input type="checkbox"/> Food cravings / increased appetite |
| <input type="checkbox"/> Tender breasts | <input type="checkbox"/> Low moods |
| <input type="checkbox"/> Backache | |

Any other symptoms:

Here is a list of common menstrual complaints (during the days of your actual period).

Tick any that apply - you can tick more than one box.

- | | |
|---|--|
| <input type="checkbox"/> Cramping or pain | <input type="checkbox"/> Heavy bleeding just on first or second day |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Heavy bleeding for the first three to four days |
| <input type="checkbox"/> Feeling especially tired | <input type="checkbox"/> Backache |
| <input type="checkbox"/> Headaches or migraines | |

Any other symptoms:

Please use this box if you want to give any further information about your female health and menstrual cycle.

Instructions on how to complete your Food Diary

What do I need to put in my food diary?



- Write down everything that you eat and drink, including all meals and snacks over the days that you are filling in the diary.
- Please state whether meals are home-made, a ready-meal, a takeaway or a restaurant meal.
- Do not be afraid to be honest. For example, if you ate three chocolate bars in one day or drank three cans of cola, please note that down. We are not here to judge, only help.
- Please be specific about quantities, if possible. For example, say “6 Brazil nuts” as opposed to just “Brazil nuts”. Or “1 chicken breast” as opposed to “chicken breast”.
- Be specific rather than generic about the types of foods you list. So if you ate fruit, please say what type, e.g. “2 apples” or “1 banana”. Please do not just put down “fruit”.
- If you have coffee or tea, please note if it is ‘normal’ or decaffeinated. If you are drinking coffee in a café, restaurant etc. please indicate what type of coffee, e.g. “espresso”, “latte with full-fat milk”. If you have herbal tea, green tea or other types of tea, please indicate which.
- If you use sugar or other similar sweeteners, please note which and how much, e.g. “2 teaspoons of honey”, or “1 teaspoon of white sugar”.
- If you drink water, please note how much in number of glasses or litres, and include details such as ‘still’ or ‘sparkling’.

Date:

DAY 1

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 2

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 3

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 4

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 5

Name:

Time	Food & Drink Consumed	Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 7

Name:

Time	Food & Drink Consumed	Where Consumed

Number of bowel movements

Exercise, including type and duration

Date:

DAY 7

Name:

Time

Food & Drink Consumed

Where Consumed

Number of bowel movements

Exercise, including type and duration