Lisapnutrition

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NUTRITION QUESTIONNAIRE

Please fill in the relevant areas, save and return to info@lisapnutrition.com at least 3 days before your consultation.

Client details (Private and Confidential)

Title		Blood pressure	
Full name		Resting pulse rate	
Date of birth		Height	
Address		Weight	
		Waist measurement	
		Hip measurement	
		Is your weight stable, increasing or decreasing?	
Email		Blood type	
Phone number		Did you have normal immunisations as a child?	
Work environment (e.g. city, farm)			
Occupation			

Health goals

What is your reason for seeking nutrition advice?	
What would you like to achieve from your consultation?	

Health profile

(Please list any health issues that you have suffered from any time throughout your life including childhood)

Health issues (e.g, diabetes)	Treatment so far	Date of onset	Duration

What medicines / supplements do you currently take on a regular basis

(Please include all medicines, vitamins, supplements, pain relief you regularity take).

Medication / supplements	Brand	Dose / day	How long taking?

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Health profile - Please click in the box next to the symptoms that you regularly experience

Skin	
Dry	
Scaly	
Premature wrinkles	
Pale	
Puffy	
Rashes	
Yellow	
Oily	
Acne	
Rosacea	
Eczema	
Psoriasis	
Boils	
Hives	
Excessive sweating	
Stretch marks	
Easy bruising	
Thread veins	
Ringworm	
Itching	

Chest	
Asthma	
Colds and infections	
Bronchitis	
Heart condition	
Palpitations	
Difficulty breathing	
Wheezing	
Short of breath	
Chest pain	

Joints	
Painful	
Inflamed	
Swollen	
Stiff	
Arthritic	
Aching	
Sore	
Unsteady	
Slow moving	
Less mobile	

Eyes	
Burning	
Protruding	
Prone to infection	
Itchy	
Painful	
Yellow	
Dry	
Cataracts	
Sensitive to light	
Bags	
Swollen eyelids	
Failing eyesight	

Head	
Headaches	
Migraine	
Stiff neck	
Dizziness	
Poor balance	
Pounding head	

Gut	
Cramping	
Irritable bowel syndrome	
Nausea	
Acid reflux	
Flatulence	
Belching	
Painful	
Bloated	
Coeliac	
Haemorrhoids	
Ulcers	
Constipation	
Diarrhoea	

Feet	
Swollen	
Aching	
Athletes foot	
Gout	
Cold feet	
Numb	

Nose	
Stuffy	
Runny	
Poor sense of smell	
Snoring	
Sinusitis	
Hay fever	
Rhinitis	
Sneezing	
Nose bleeds	

Hair	
Oily	
Dry	
Brittle	
Prematurely grey	
Thinning	
Dandruff	
Increased hair	
Decreased hair	

Genitals	
Cystitis	
Warts	
Frequent urination	
Herpes	
Inflamed prostate	
Impotence	
Painful intercourse	
Vaginal dryness	
Thrush	

Nails	
Fragile	
Peeling	
Splitting	
Ridges	
White spots	
Infected	
Dry	
White lines	
Thick nails	
Dark nails	
Split cuticles	

Mouth	
Sore tongue	
Tooth decay	
Difficulty swallowing	
Bad breath	
Sore throats	
Mouth ulcers	
Dry mouth	
Excess saliva	
Inflamed gums	
Bleeding gums	
Cold sores	

Muscles	
Tender	
Cramps	
Spasms	
Loss of tone	
Weak	
Stiff	
Restless legs	
Numbness	

Mood and mind	
Difficulty concentrating	
Anxious	
Angry	
Unmotivated	
Hyperactive	
Easily upset	
Overwhelmed	
Suicidal	
Forgetful	
Depressed	
Dyslexia	
Dyspraxia	
Panic attacks	

Ears	
Blocked	
Sore	
Itchy	
Weeping	
Overly waxy	

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Family history

Do you have a family history of disease or allergies? (e.g. Cancer, heart disease, asthma)	
Grandparents	
Parents	
Siblings	

Lifestyle questions

Your daily life	
Do you enjoy your daily life?	
How many people depend on you?	
Do you feel supported by people around you?	
Are you recently separated / divorced / a new parent?	
Are you recently bereaved?	
Have you moved house or changed jobs recently?	
Do you work long or irregular hours or shift work?	
Is your workload bigger than you can imagine?	
Are you under significant stress in any other way?	
Do you feel guilty when you are relaxing?	
Do you have a strong drive for achievement?	
Do you often do 2 or 3 tasks simultaneously?	
Do you take regular exercise?	
Is your job active?	
Do you have any active hobbies?	
Do you sleep well?	
What do you do for relaxation?	

Your digestion	
Do you get indigestion after meals?	
Do you get indigestion after fatty food?	
Do you have a bowel movement shortly after eating?	
Do you have frequent stomach upsets or pain?	
Do you regularly feel nauseous or vomit?	
Do you have pain between your shoulders or under your ribs?	
Do you have undigested food in stools?	
Do you have generally inconsistent bowel movements?	
Do you have anal itching?	
How many bowel movements do you have in 24 hours?	
Are your stools pale, mid brown, dark brown, or black?	
Have you had a stomach upset after foreign travel?	
Do any food cause digestive problems? Which ones?	

Your toxic exposure	
Do you live, exercise or work in a busy road?	

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Do you live close to an agricultural area?	
Do you drink unfiltered water?	
Do you drink alcohol? If so, how many units a week?	
What is your normal alcoholic drink?	
Do you smoke? If so, how many a day?	
Do you think you may be addicted to anything?	
Do you spend a lot of time in front of a TV?	
Do you sunbathe a lot?	
Are you a frequent flyer?	
Are you exposed to chemicals through work or hobby?	
Do you heat, freeze or wrap foods in plastic?	
Do you cook or wrap food in aluminium?	
Do you regularly take antacid (indigestion) medication?	
Do you frequently fry or roast foods?	
Do you regularly eat browned or barbecued foods?	
Do you eat oily fish or shellfish more than 3 x a week?	
Do you regularly consume sweeteners?	
Do you floss your teeth regularly?	
Are your teeth filled with mercury amalgams?	

Your energy levels	
Do you need more than 8 hours sleep per night?	
Is your energy less than it used 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 quickly?	
Do you suffer from unexplained fatigue?	

Eating habits	
Which are your favourite foods?	
Which foods do you dislike?	
Which foods do you crave?	
Which foods would you find hard to give up?	
Do you cater for a special diet in your household?	
Who does the cooking in your household?	
Are you vegetarian / vegan?	
Do you avoid any foods for cultural/ethical reasons?	
Do you suspect any foods don't agree with you?	
Have you recently changed your diet?	
Do you eat on the move / when stressed?	
Do you have binges? If so, what do you binge on?	
Have you ever suffered from an eating disorder?	
Do you chew your food thoroughly?	
Are you excessively thirsty?	

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Women only	
Are you pregnant? If so, how many weeks?	
Are you trying to become pregnant?	
Are you breast-feeding at present?	
How many children have you had?	
Have you had any problems with fertility?	
Have you ever had a miscarriage?	
What contraception do you use?	
Are you still menstruating?	
Are you or have you been on HRT?	
Are your periods regular?	
Do you have any bleeding or spotting in between?	
Are your periods particularly heavy or painful?	
Do you suffer from PCOS, fibroids or endometriosis?	
Are you happy with your sex drive?	

Men only	
Do you experience mood swings or depression?	
Do you have a loss of sex drive?	
Do you have loss of motivation and drive?	
Do you have fertility problems?	
Do you have problems achieving or maintaining an erection?	
Do you have frequent or difficult urination?	
Do you have prostate problems?	
Do you wake at night to urinate?	
Do you find it difficult to start or stop urine stream?	
Do you have pain or burning when urinating?	

Additional information	
Is this your first visit to a Nutritionist?	
How did you find out about me?	
GP's name	
GP's Address	

Are any other therapists / clinics involved in your care? Please list.	
Would you like to receive my FREE monthly newsletter by email?	Yes

I have disclosed all the relevant information applicable to this consultation and my health at this point in time. I consent for the information provided to be used by my nutritionist and to liase with appropriate health care professionals.

Date:		**Sign:**	

Please type your name here if submitting online or sign during consultation

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