

Nutritional Assessment Questionnaire

Please complete as clearly, completely and accurately as possible (don't worry if there are some details you don't know). Then return, to arrive at least two days before your consultation, to:
David Riley, 28 Hawker Way, Woodley, Reading, RG5 4PF

**PRIVATE AND
CONFIDENTIAL**



PERSONAL DETAILS

Title (Mr/Mrs/Ms/Dr etc): First Name: Last Name:

Address:

..... Post Code:

Phone Numbers: Email:

Date of Birth: Age: Occupation:

Is your GP aware you are having nutritional therapy? (Y/N): Do you give your permission for your GP to be contacted?:

GP's Name: Address:

..... Post Code:

Is this your first visit to a nutritional therapist? (Y/N): How did you hear of me? :

HEALTH PROFILE

What is your main reason for seeking nutritional advice?:

List the outstanding health problems you have and indicate how long you have had them (use a separate sheet if necessary):

Health Problem	Duration
1.
2.
3.
4.
5.

Under what circumstances do these problems get worse?:

Under what circumstances do they improve?:

Do you have any hereditary / chronic health conditions (e.g. type 1 diabetes):

List any major surgery or significant periods of ill health in your life and any chronic or niggling health problems:

.....

.....

Give details (date, reason) of any antibiotic use in the past 12 months?:

List any prescribed medications you are currently taking (name and dose):

.....

Your weight: Height: Blood Pressure: Resting Pulse Rate:

Give details of any medical tests you have had recently, with results if known:

.....

FAMILY HEALTH PROFILE

Do you have any brothers and sisters? State their age and sex:

Do you have any children? State their age and sex:

Do/did your brothers, sisters, parents or grandparents suffer from any illnesses (e.g. heart disease, diabetes, asthma etc)? Give details:

.....

.....

SYMPTOM ANALYSIS

Please read through the symptoms listed below and place a tick against any that you are presently aware of. Some of the symptoms are listed more than once – please tick them in all cases.

- Mouth ulcers.**
- Poor night vision.
- Acne.
- Frequent colds or infections.**
- Dry flaky skin.
- Dandruff.
- Thrush or cystitis.
- Diarrhoea.

- Rheumatism or arthritis.**
- Back ache.
- Tooth decay.
- Hair loss.
- Excessive sweating.
- Muscle cramps or spasms.
- Joint pain or stiffness.**
- Lack of energy.

- Lack of sex drive.
- Exhaustion after light exercise.**
- Easy bruising.**
- Slow wound healing.**
- Varicose veins.
- 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.
- Cracked lips.

- 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.
- Lack of energy.
- Exhaustion after light exercise.
- Anxiety or tension.
- Teeth grinding.

- Infrequent dream recall.
- Water retention.**
- Tingling hands.
- Depression or nervousness.
- Irritability.
- Muscle tremors or cramps.
- Lack of energy.**
- Flaky skin.

- Poor hair condition.
- Eczema or dermatitis.
- Mouth oversensitive to hot or cold.
- Irritability.
- Anxiety or tension.
- Lack of energy.**
- Constipation.
- Tender or sore muscles.
- Pale skin.

- Eczema.
- Cracked lips.
- Prematurely greying hair.
- Anxiety or tension.
- Poor memory.
- Lack of energy.**
- Poor appetite.
- Stomach pains.
- Depression.

- Dry skin.**
- Poor hair condition.
- Prematurely greying hair.
- Tender or sore muscles.**
- Poor appetite or nausea.**
- Eczema or dermatitis.**

- 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.**

- Muscle tremors or spasms.**
- Muscle weakness.
- Insomnia or nervousness.
- High blood pressure.
- Irregular heart beat.
- Constipation.
- Fits or convulsions.
- Hyperactivity.
- Depression.

- Pale skin.**
- Sore tongue.**
- Fatigue or listlessness.**
- Loss of appetite or nausea.**
- Heavy periods or blood loss.**

- Poor sense of taste or smell.
- White marks on more than 2 finger nails.**
- Frequent infections.
- Stretch marks.
- Acne or greasy skin.
- 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.**
- Dizziness or irritability after 6 hours without food.**
- Need for frequent meals.
- Cold hands.
- Need for excessive sleep or daytime drowsiness.
- Excessive thirst.
- 'Addicted' to sweet foods.**

LIFESTYLE ANALYSIS

Please read through the questions below and place a tick against any that apply to you.

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 more than 5 cigarettes a day?
- Do you do less than 2 hours exercise a week?
- Do you eat more than one spoonful of sugar a day?
- Do you eat red meat more than 5 times a week?
- Do you usually add salt to your food?
- Do you have more than 2 alcoholic drinks a day?
- Is there a history of heart disease in your family?

Exercise Profile

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

Pollution 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 (*jog, cycle, play sports*) by busy roads?
- Do you smoke more than 5 cigarettes a day?
- 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 of alcohol a day?
- Do you spend a lot of time in front of a TV or PC screen?
- Do you usually drink unfiltered tap water?

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, like a tea, coffee or cigarette?
- Do you have tea, coffee, sugary 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 hay fever?
- Do you suffer from allergy problems?
- Have you had a major personal loss in the last year?

Allergy Profile

Please tick if you suffer from any of the following:

- Asthma. Eczema. Dermatitis. Migraine.
- Irritable bowel. Frequent bloating. Facial puffiness.

Do you have any allergies? If so, to what?

State type of reaction: _____

Have they been tested?: _____

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?
- Please state which:
- Are your periods regular?
- Are you post-menopausal?

Please tick if you suffer from any pre-menstrual symptoms:

- Bloating. Tiredness. Irritability.
- Depression. Headaches. Breast tenderness.

Additional Questions for Men Only

- Do you have any prostate problems?
- Do you wake regularly at night to urinate?
- Do you find it difficult to start & stop the urine stream?
- Do you have pain or a burning sensation when urinating?

METABOLIC PROFILE

Please tick the following statements that apply to you:

- | | |
|--|--|
| <input type="checkbox"/> Come from an all girl family. | <input type="checkbox"/> Family history of depression. |
| <input type="checkbox"/> Addictive or obsessive personality. | <input type="checkbox"/> Tendency to sneeze in bright sunlight. |
| <input type="checkbox"/> Cry easily. | <input type="checkbox"/> Little body hair. |
| <input type="checkbox"/> Copious salivation. | <input type="checkbox"/> Long fingers and toes. |
| <input type="checkbox"/> Rarely remember dreams. | <input type="checkbox"/> Low tolerance of pain. |
| <input type="checkbox"/> Pale skin. | <input type="checkbox"/> Strong sex drive. |
| <input type="checkbox"/> Crowded upper front teeth. | <input type="checkbox"/> Hardly ever put on weight (" <i>I can eat what I like</i> "). |
| <input type="checkbox"/> Definite body or breath odour. | <input type="checkbox"/> Easily put on weight. |
| <input type="checkbox"/> Sensitive to drugs or alcohol. | <input type="checkbox"/> "Hyperactive" (<i>can't sit still for 5 minutes</i>). |

DIGESTIVE ANALYSIS / EATING HABITS

- | | |
|--|--|
| Were you breast fed? | How many coffees do you drink each day? |
| Was a significant proportion of your diet as a child high in sweet or fatty foods? | How many cups of tea do you drink each day? |
| Do you go out of your way to avoid foods containing additives or preservatives? | Do you mainly drink decaffeinated coffee or herbal tea? |
| Do you try to avoid foods containing sugar? | How many teaspoons of sugar do you add to food or drinks each day? |
| Do you add salt to your food or use it in cooking? | How many pints of milk do you drink each week? |
| What % of your diet is raw fruit or veg. (inc. salad)? | How many times a week do you have meals containing fried food? |
| Do you normally eat white bread or rice? | How many times a week do you eat "junk" food? |
| What is your usual alcoholic drink?: | How many times a week do you eat "ready" meals? |
| How many units do you drink each week? | How many times a week do you eat chocolate or confectionary? |
| Do you use a water filter or drink bottled rather than tap water? | How many cans of food do you eat each week? |
| Do you frequently eat under stressful conditions? | How many slices of bread or rolls do you eat each week? |
| Does your job involve eating out a lot? | How many times a week do you eat red meat (beef, pork, lamb; incl. ham, sausages, burgers)? |
| How would you describe your appetite? | How many times a week do you eat white meat or fish? |
| 1 = poor 2 = average 3 = good | How many times a week do you eat oily fish (salmon, mackerel, pilchards, whitebait, fresh tuna, etc.)? |
| Do you or can you cook for yourself? | How many glasses of water do you drink each day? |
| Do you enjoy cooking? | How many portions of fruit / veg. do you eat each day? |
| Do you mainly purchase organic produce? | |
| Have you recently changed your diet? | |
| Do you steam vegetables rather than boiling? | |

FOOD PREFERENCES

- List any foods you avoid for religious / cultural / ethical / health reasons:
-
- List any foods that you suspect "don't agree with you":
-
- List any foods you would find hard to give up:
- List any foods you crave:
- List any foods you dislike:

NUTRITIONAL SUPPLEMENTS ETC

- List any nutritional supplements and "over the counter" medications (e.g. antacids) you take on a regular basis. Where possible provide name, brand and dose:
-

FOOD DIARY

Record all of the foods and drinks you consume over the next 3 days. Include as much information as you can, such as brand names, amount eaten, whether food was fresh or frozen/canned etc, how it was cooked.

Day 1 - Date:
Breakfast: (Time:)
Lunch: (Time:)
Dinner: (Time:)
Snacks & Drinks: (indicate times if possible)

Day 2 - Date:
Breakfast: (Time:)
Lunch: (Time:)
Dinner: (Time:)
Snacks & Drinks: (indicate times if possible)

Day 3 - Date:
Breakfast: (Time:)
Lunch: (Time:)
Dinner: (Time:)
Snacks & Drinks: (indicate times if possible)

If the last 3 days are not typical of your usual eating habits please indicate what the diet of a more typical day would be:

Breakfast: (Time:)
Lunch: (Time:)
Dinner: (Time:)
Snacks & Drinks: (indicate times if possible)

Terms of Business

David Riley BSc(Hons) Dip.ION Dip.Couns MBANT ARCS
ADR Nutrition, 28 Hawker Way, Woodley, Reading, RG5 4PF



Please read the paragraphs below then sign both copies of this sheet. Keep one copy for yourself and bring the other along to your initial consultation.

1. The Nutritional Assessment Questionnaire and 3-day food diary sent to you should be returned to ADR Nutrition to arrive at least 48 hours prior to the initial consultation. Failure to return them in time may result in the consultation being postponed.
2. You may cancel any appointment but please try to give at least 48 hours notice. If you cancel with less than 24 hours notice you may be charged 50% of the full consultation fee.
3. Consultation fees are as set out on ADR Nutrition's web site. The fee for each consultation is payable either by cash or cheque at the end of the consultation –please remember to bring your cheque book with you. At certain clinics credit card facilities may be available, please ask for details.
4. The suitability of the nutritional advice and guidance you are given depends to a large extent on the accuracy with which you complete the questionnaire and food diary (although clarifications may be made during the consultation). No responsibility can be accepted if important information is withheld. In particular, you should give full details of diagnosed medical conditions and any medications being taken, details of any changes in diagnoses and/or medication which occur whilst you are following your nutritional programme and full details of any nutritional supplements, homeopathic or herbal preparations you are taking.
5. The benefit achievable from nutritional therapy varies between individuals with similar health concerns and following similar nutritional therapy programmes. No claim is made as to the efficacy of any nutritional protocol.
6. The results you obtain from your nutritional therapy programme will also depend upon your degree of compliance with the advice provided. No responsibility can be accepted in cases of non-compliance.
7. It is your responsibility to inform your doctor of the nutritional programme you are following and you are advised to do so even if you are not being treated by him/her. This is to avoid any undesirable interactions between medication and the nutritional programme.
8. To avoid adverse reactions it is important that you do not continue your nutritional programme beyond the agreed time period.
9. You will be fully involved in the decision making process regarding the options to be included in your nutritional programme. Either during or after your initial consultation you will be sent details of the programme, including dietary and lifestyle recommendations and a nutritional supplement programme.
10. Your nutritional programme may, with your agreement, include biochemical tests and/or nutritional supplements. These must be paid for at the end of the consultation, in the same way as for the consultation fee. Please note that ADR Nutrition has no underlying business interest in any specific manufacturer or supplier.
11. If you are at all unclear about the nutritional programme (including, but not limited to, nutritional supplement dosages, time periods etc) you should contact your nutritional therapist promptly for clarification.
12. Do not be tempted to modify the programme on the advice of a third party, without the consent of your nutritional therapist.
13. Nutritional therapists are not permitted to diagnose or claim to treat any medical condition. Nutritional advice is not a substitute for professional medical treatment. The aim of nutritional therapy is to facilitate the body's own re-balancing and self-healing in an attempt to alleviate undesirable ill-health conditions. You are responsible for contacting your doctor with regard to any health concerns you may have.
14. Standards of professional practice in nutritional therapy are governed by the British Association for Applied Nutrition and Nutritional Therapy (BANT) Code of Ethics and Practice. BANT may be contacted at: 27 Old Gloucester Street, London WC1N 3XX (tel/fax: 08706 061284) or via its web site at <http://www.bant.org.uk>.

Data Protection

The information you provide on the Nutritional Assessment Questionnaire and that gathered during consultations is recorded in writing by ADR Nutrition and may be transferred to computer. It includes personal data relating to your health and brief details of your family unit. ADR Nutrition will process and hold this data for future reference. Other (non-medical) personal information may be used for the purposes of administration only. We can confirm that we take careful measures to keep all such information secure. Our policy is not to disclose it to any third party without your written consent. Returning this form duly signed constitutes your express consent to the processing of this data.

I understand the above and agree that our professional relationship will be based on the content of this document.

Signed by the client: Date:

Signed by the therapist: Date:

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6. The results you obtain from your nutritional therapy programme will also depend upon your degree of compliance with the advice provided. No responsibility can be accepted in cases of non-compliance.
7. It is your responsibility to inform your doctor of the nutritional programme you are following and you are advised to do so even if you are not being treated by him/her. This is to avoid any undesirable interactions between medication and the nutritional programme.
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I understand the above and agree that our professional relationship will be based on the content of this document.

Signed by the client: Date:

Signed by the therapist: Date: