**NUTRITION QUESTIONNAIRE**

**Please answer Yes, No or I don’t know:**

|  |  |
| --- | --- |
| Cardiovascular system (1 point for each yes) | YES NO |
| Are you more than 14lbs (7kgs) overweight? |  |
| Do you smoke more than 5 cigarettes a day? |  |
| Is there a history of heart disease in your family? |  |
| Do you have more than two alcoholic drinks a day? |  |
| Do you usually add salt to your food? |  |
| Do you eat red meat more than give times a week? |  |
| Do you use more than one spoonful of sugar a day? |  |
| Do you do less than two hours exercise a week? |  |
| Is your blood pressure above 140/90? |  |
| Is your pulse after 15 minutes rest above 75? |  |
| **Total scores for cardiovascular system** |  |
| Digestive System (1 point for each yes) | YES NO |
| Do you suffer with constipation or diarrhoea? |  |
| Do you experience anal irritation? |  |
| Do you suffer from flatulence or bloating? |  |
| Do you occasionally use indigestion tablets? |  |
| Do you find it difficult digesting fatty foods? |  |
| Do you ever get a burning sensation in your stomach? |  |
| Are you prone to stomach upsets? |  |
| Do you use any type of butter or margarine on a daily basis? |  |
| Do you eat quickly/rush your food/eat under stress? |  |
| Do you normally eat at irregular times? |  |
| **Total scores for digestive system** |  |
| Endocrine/reproductive systems (1 pint for each yes) | YES NO |
| Are you taking or have you ever taken the Pill and/or HRT? |  |
| Have you ever had a miscarriage? |  |
| Do you suffer with any PMS symptoms? |  |
| Do you have difficulty in losing weight? |  |
| Do you suffer from lumpy breasts? |  |
| Do you suffer from breast tenderness? |  |
| Do you often feel tired during the day? |  |
| Do you often do two or tree tasks simultaneously? |  |
| Do you have difficulty in getting to sleep? |  |

|  |  |
| --- | --- |
| Lymphatic System & Immunity (1 point for each yes) | YES NO |
| Is there a history of cancer in your family? |  |
| Do you find it hard to shift an infection? |  |
| Do you sit still for several hours each day? Work/TV |  |
| Do you avoid physical exercise? |  |
| Do you have cellulite? |  |
| Do you work harder than most people? |  |
| Do you feel guilty when relaxing? |  |
| Do you have a persistent need for achievement? |  |
| Are you especially competitive? |  |
| Have you taken antibiotics over the past two years? |  |
| **Total scores for lymphatic and immunity system** |  |
| Respiratory (2 points for each yes) | YES NO |
| Do you smoke more than 5 cigarettes a week? |  |
| Do you live or work in a smoky atmosphere? |  |
| Do you suffer from frequent bronchitis, asthma, cold and flu? |  |
| Do you live on a main road? |  |
| Do you spend more than 2hrs a week in heavy traffic? |  |
| Do you eat non-organic vegetables? |  |
| Do you live or work in a chemical atmosphere? (thinners, mercury, paints, hairsprays, colours etc) |  |
| Do you eat fruit and vegetables without washing them first? |  |
| Do you eat fried foods more than twice a week? |  |
| **Total scores for respiratory system** |  |
| Skeletal System (2 points for each yes) | YES NO |
| Do you consume more than one pint of milk per day? |  |
| Do you avoid weight-bearing exercise |  |
| Do you eat less than five portions of green leafy vegetables and fruit on a daily basis? |  |
| Do you east sweet, sugary foods on most days? |  |
| Do you suffer with any type of arthritis? |  |
| **Total scores for the skeletal system** |  |
| Urinary/Detoxification Systems (1 point for each yes) | YES NO |
| Do you suffer with fluid retention? |  |
| Have you ever suffered with thrush or cystitis? |  |
| Do you suffer from chronic fatigue? |  |
| Do you have more than 14 units of alcohol (women) or 21 units of alcohol (men) a week? |  |
| Do you suffer with eczema or psoriasis? |  |
| Do you suffer from acne or poor skin condition? |  |
| Do you feel you have a sensitivity to chemicals? |  |
| Do you have any explained itching? |  |
| Do you suffer with dull headaches? |  |
| **Total scores for the urinary/detoxification systems** |  |
| Nervous System (2 points for each yes) | YES NO |
| Do you suffer from any type of headache? |  |
| Do you suffer with migraine headaches? |  |
| Do you suffer with panic attacks? |  |
| Do you often find that you are irritable/jumpy? |  |
| Do you feel that you lose your temper easily? |  |
| **Total scores for the nervous system** |  |
| Muscular System – energy (1 point for each yes) | YES NO |
| Is your energy less now than it used to be? |  |
| Do you avoid exercise due to tiredness? |  |
| Do you sweat a lot or get excessively thirsty? |  |
| Do you get dizzy or irritable if you don’t eat often? |  |
| Do you often feel drowsy during the day? |  |
| Do you sometimes lose concentration? |  |
| Do you suffer with cramps? |  |
| Do you suffer with muscular aches and pains? |  |
| Do you have much injury through playing sport? |  |
| Do you drink less than eight glasses of water every day? |  |
| **Total score for the muscular system** |  |

|  |
| --- |
| **TOTAL SCORES** |
|  |  |
| Cardiovascular |  |
| Digestive System |  |
| Endocrine/reproductive system |  |
| Lymphatic system and immunity |  |
| Respiratory system |  |
| Skeletal system |  |
| Urinary and detoxification system |  |
| Nervous system |  |
| Muscular system and energy |  |
| System(s) with highest score |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Height: (cm/metres/feet)……………………. | Weight: (lbs/kg/stone)…………………….. | Hip: cm only…………………….. | Waist: cm only…………………….. |

**Food preparation:**

State how often you eat or drink the following foods:

|  |  |
| --- | --- |
| Foods:   | No. of times:per day / per week / per month / never |
| 1. Raw foods e.g. fruit and vegetables |  |
| 2. Fruit juice |  |
| 3. Dried fruit |  |
| 4. Frozen vegetables/fruits |  |
| 5. Organic fruit and vegetables |  |
| 6. Steamed vegetables |  |
| 7. Stir fried vegetables |  |
| 8. Salads |  |
| 9. Pre-packed foods |  |
| 10. Take-aways |  |
| 11. Eat out |  |
| 12. Low fat alternative food |  |
| 13. Margarine |  |
| 14. Alcohol |  |
| 15. Coffee and tea |  |
| 16. Carbonated or soft drinks |  |
| 17. Refined foods (white bread, white pasta, polished rice) |  |
| 18. Olive oil, nuts, seeds, avocado |  |
| 19. Oily fish, flaxseed, walnut oil, dark green vegetables |  |
| 20. Glasses of water |  |

What are your favourite foods and how often do you eat them:

|  |  |
| --- | --- |
| Food | How often eaten |
|  |  |
|  |  |
|  |  |
|  |  |

How often do you miss/skip meals? What is your favourite snack food?

What in your opinion are healthy foods?

What in your opinion are unhealthy foods?

**VITAMIN & MINERAL ANALYSIS**

*Please tick or circle any symptoms that apply to you. Tick them on each occasion they arise, even if they are repeated.*

**A**

**Mouth ulcers** Poor night vision Acne **Frequent colds/infections**

Dry, flaky skin Dandruff Thrush/cystitis Diarrhoea

**B1**

Tender muscles Eye pains Irritability Poor concentration Poor memory

Stomach pains Constipation Tingling hands Rapid heart beat Restless/prickly legs

**B2**

**Burning/gritty eyes**  **Sensitivity to bright light Sore tongue** Cataracts

Dull or dry hair Eczema/dermatitis Split nails

**B3**

Lack of energy Diarrhoea Insomnia Headaches/migraines Poor memory

Anxiety/tension Depression/irritability Eczema/dermatitis Bleeding/tender gums Acne

**B5**

Muscle cramps or tremors Apathy Poor concentration **Burning feet** Nausea/vomiting

Lack of energy Exhaustion after light exercise Anxiety/tension Teeth grinding

**B6**

Infrequent dream recall **Water retention(oedema)** Tingling hands Flaky skin

Depression/nervousness Muscle cramps or tremors **Lack of energy** Irritability

**B12**

Poor hair condition Eczema/dermatitis Mouth oversensitive to cold or hot Irritability

Anxiety/tension **Lack of energy**  Constipation Tender or sore muscles Pale skin

**Folic Acid**

Eczema Cracked lips Prematurely greying hair Anxiety/tension Poor memory

**Lack of energy** Depression Poor appetite Stomach pains

**Biotin**

Dry skin Poor hair condition Prematurely greying hair **Tender/sore muscles**

**Poor appetite or nausea** **Eczema/dermatitis**

**C**

**Frequent colds Frequent infections** Lack of energy Bleeding or tender gums

Easy bruising Nose bleeds Slow wound healing Red pimples on skin

**D**

**Rheumatism/arthritis Joint pains/stiffness** Backache Tooth decay

Excessive sweating Muscle cramps/spasms Lack of energy Hair loss

**E**

**Exhaustion after light exercise Easy bruising Slow wound healing**

Varicose veins (Piles) Infertility Lack of sex drive (libido)

**GLA**

**Dry/rough skin** Dry eyes Frequent infections Poor memory Infertility

Loss of hair or dandruff Excessive thirst Poor wound healing PMS or breast pain

**Calcium**

**Muscle cramps/tremors Insomnia or nervousness Joint pain or arthritis**

**Tooth decay High blood pressure**

**Magnesium**

**Muscle tremor/spasms** Muscle weakness Insomnia/nervousness Depression

High blood pressure Irregular heart beat Constipation Hyperactivity

**Iron**

**Pale skin Sore tongue Fatigue/listlessness Loss of appetite/nausea**

**Heavy periods/blood loss**

**Zinc**

**White marks on more than 2 fingernails**  Poor sense of taste/smell Pale skin

Frequent infections Stretch marks Acne or greasy skin Low fertility/poor sex drive

Tendency to depression Poor appetite Childhood ‘growing pains’

**Manganese**

**Muscle twitches Dizziness/poor balance** Sore knees

**Selenium**

**Family history of cancer Signs of premature ageing Cataracts**

**High blood pressure Frequent infections**

**Chromium**

**Excessive or cold sweats Dizziness or irritability after 6 hours without food**

Need for frequent meals Cold hands Excessive sleep/drowsiness during the day

Excessive thirst **Regular consumption of sweet foods**

**Activity levels:**

How long do you sit per day?

How many hours are you active per day?

Do you do exercise that raises your heartbeat considerably for at least 20 minutes

more than 3 times a week? Yes No

Do you:

Walk daily Yes No

Do the gardening? Yes No

Do the cleaning? Yes No

Drive everywhere? Yes No

**Stress levels:**

How stressful is your home and work life in general? Please tick one under each category

**Home:** Mild Moderate Severe

**Work**: Mild Moderate Severe

**Meal times**: Mild Moderate Severe

What are your **objectives** and what do you hope to achieve?

Thank you for your time. Please now complete the attached diary and then pass it back to me at your convenience.

In the meantime, if you have any queries or need any help in completing the questionnaire, please do not hesitate to contact me.

All information will be treated confidentially.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Declaration**

**Client Information**

Please read carefully and only sign if you are in full agreement with its contents.

The VW Nutritional Coaching service requests that the client notes the following:

* The coaching service will be tailored to support health conditions and/or health concerns identified on the health questionnaire
* I am not permitted to diagnose, or claim to treat, medical conditions.
* The VW Nutritional Coaching service is not a substitute for professional medical advice and/or treatment.

The client understands and agrees to the following:

You are responsible for contacting your GP about any health concerns.

If you are receiving treatment from your GP or any other medical provider you should tell him/her about any nutritional strategy provided by a Nutritional Therapist. This is necessary because of any possible reaction between medication and the nutritional programme.

It is important that you tell me about any medical diagnosis, medication, herbal medicine or food supplements you are taking as this may affect the nutritional programme.

If you are unclear about the agreed programme/food supplement doses/time period, you should contact me promptly for clarification.

You must contact me should you wish to continue any specified supplemental programme for longer than 3 months, to avoid any potential adverse reactions. In any case I recommend a regular review of supplements to ensure they remain appropriate to your needs.

Please note I do recommend that all supplements are taken at different times of the day to any prescribed medications

***We would always recommend you discuss any dietary or supplemental concerns or changes you wish to make with your GP. Medication should never be discontinued or dosage amended without your GP’s prior knowledge and agreement.***

I understand the above and agree that the health nutritional questionnaire provided by VW Nutritional Coaching Service will be based on the content of this document. I declare that all the information on this questionnaire is confidential and, to the best of my knowledge true

and correct.

Name of Client: ...................... Client Signature: ………………………….. Date: ………….