HEALTH QUESTIONNAIRE

(to be completed and returned
3 days prior to first consultation)

EQUILIBRIO

CLAIRE SAMBOLINO Nutrition MSc

PERSONAL INFORMATION

NAME *(including title)*	
ADDRESS	
TELEPHONE	
MOBILE	
EMAIL ADDRESS	
DATE OF BIRTH	
SEX	
HEIGHT	
WEIGHT	
BODY MASS INDEX (BMI)	

visit http://www.nhs.uk/tools/pages/healthyweightcalculator.aspx)

FAMILY & PROFESSIONAL LIFE

OCCUPATION	
MARITAL STATUS	
NUMBER OF CHILDREN AND/OR DEPENDENTS	
TOTAL N° OF PEOPLE IN FAMILY UNIT	
ARE YOU THE MAIN FOOD SHOPPER?	
ARE YOU THE MAIN COOK IN THE FAMILY?	
DO YOU HAVE AUTONOMY OVER YOUR DIET?	

DECLARATION:

The information I have provided on this health questionnaire is accurate to the best of my knowledge:

Name (Capitals):.....

Date:.....

Signature:.....

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REASON/S FOR SEEKING NUTRITIONAL SUPPORT

Please describe your health goals and reasons for seeking support.

HAVE YOU EVER HAD ANY PREVIOUS NUTRITIONAL SUPPORT?

Please describe any previous therapies and health outcomes

DO YOU CURRENTLY USE ANY NUTRITIONAL SUPPLEMENTS?

Please list any current supplements (including brands, doses, frequency and duration)

WHAT HAVE YOU EATEN IN THE LAST 24 HOURS?

Please provide a brief description of the foods and drinks you have consumed over the past 24 hours
(A full 3-day food diary is included later in the questionnaire for your completion)

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APPETITE AND EATING HABITS

GOOD APPETITE ☐	POOR APPETITE ☐	CRAVES SUGARY FOODS ☐
ENJOYS COOKING ☐	DOESN'T COOK ☐	COMFORT/STRESS EATER ☐
EATS EVERY 3 HOURS OR LESS ☐	PICKY EATER ☐	EATS ON THE GO ☐

ARE THERE ANY FOODS YOU CHOOSE TO AVOID?

(For personal choice or cultural/religious/ethical reasons, or following specific diet)

ARE THERE ANY FOODS WHICH YOU CRAVE, OR WOULD FIND HARD TO GIVE UP?

ARE THERE ANY FOODS YOU DISLIKE OR WOULD HAVE DIFFICULTY INCORPORATING INTO A NEW DIET?

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PERSONAL HEALTH HISTORY

Please list all significant health problems that you have encountered in your lifetime.

HEALTH PROBLEM	DURATION	MANAGEMENT *(medication, supplement, therapies)*

FAMILY HISTORY

Is there any history of health problems or disease in your family?

Completion of this section enables your therapist to understand your health problems in the wider context of your family history.

FAMILY MEMBER	YES/ NO	HEALTH PROBLEM
MATERNAL GRANDFATHER		
MATERNAL GRANDMOTHER		
PATERNAL GRANDFATHER		
PATERNAL GRANDMOTHER		
FATHER		
MOTHER		
BROTHERS		
SISTERS		
SONS		
DAUGHTERS		

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MEDICAL CONDITIONS & MEDICATIONS (IN DETAIL)

This section helps provides more detail on diagnosed conditions, medications, supplementation use and other therapies that you are currently or have previously used.

PLEASE LIST ALL **CURRENT** MEDICALLY DIAGNOSED CONDITIONS	YEAR DIAGNOSED	DURATION
PLEASE LIST ALL **CURRENT** MEDICATIONS (include prescribed and over the counter)	DOSE & FREQUENCY	DURATION
PLEASE LIST ANY **PREVIOUS** MEDICALLY DIAGNOSED CONDITIONS (excluding colds and flu)	YEAR DIAGNOSED	DURATION AND CURRENT STATUS (ongoing or resolved)
PLEASE LIST ANY **PREVIOUS** TREATMENTS & THERAPIES	DOSE & FREQUENCY	DURATION AND CURRENT STATUS (ongoing or resolved)

UNEXPLAINED SYSMPTOMS

Please indicate if you currently have any unexplained symptoms which may need referral to a medical practitioner *(This may include; unexplained pain/bruising/rash, unexplained bleeding in stool/urine/vomit, dizziness, blurred vision, numbness, lumps and swellings, unexplained discharges, excessive thirst/weight gain/weight loss, headaches, persistent cough, slurred speech, shortness of breath, paralysis)*

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HEALTH SYMPTOMS

PLEASE TICK ALL APPROPRIATE SYMPTOMS

This section helps identify areas of possible functional imbalance by bodily system.

DIGESTIVE SYSTEM					
Indigestion	☐	Vomiting	☐	Loss of appetite	☐
Acid reflux	☐	Sores in, or around mouth	☐	Difficulty swallowing	☐
Fullness after eating	☐	Stomach cramps	☐	Often eat on the move	☐
Bloating	☐	Flatulence	☐	Bolt food	☐
Belching	☐	Pain under right rib-cage	☐	Eat when stressed	☐
Nausea	☐	Food sits in stomach a long time	☐	Heartburn	☐

URINARY SYSTEM					
Frequent urination	☐	Urinary incontinence	☐	Urinary infections	☐
Urinary urgency	☐	Dark / offensive urine	☐	Blood in urine	☐

ELIMINATION					
Infrequent bowel action	☐	Blood in stools	☐	Anal irritation	☐
Constipation	☐	Mucus in Stools	☐	Haemorrhoids	☐
Diarrhoea	☐	Offensive stool	☐	Pale / Bulky stool	☐

HAIR AND NAILS					
Dry, brittle hair	☐	Receding hair line	☐	Excess body hair	☐
Thinning hair (head)	☐	Thinning hair (body)	☐	Brittle nails	☐

SKELETAL					
Joint pain or stiffness	☐	Muscular pain or stiffness	☐	Muscular weakness	☐
Osteoporosis	☐	Brittle bones	☐	Fractures	☐

MOOD					
Anxiety/tension	☐	Depression	☐	Stress	☐
Anger	☐	Easily provoked	☐	Frustration	☐
Passive	☐	Irritable	☐		

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PLEASE TICK ALL APPROPRIATE SYMPTOMS

WEIGHT					
Inability to gain weight	☐	Inability to lose weight	☐	Weight fluctuates/yo-yos	☐
Water retention	☐	Abdominal weight	☐	Weight on hips and thighs	☐
Unexplained weight gain	☐	Unexplained weight loss	☐		

ENERGY					
Asleep after midnight	☐	Difficulty waking up	☐	Feel unrefreshed after sleep	☐
Feel sleepy during the day	☐	Feel tired all the time	☐	Needs more than 8 hours	☐
Wakes up during the night	☐	Insomnia	☐	Difficulty getting to sleep	☐
Shift worker	☐	Disordered sleep pattern	☐		

WOMEN ONLY					
Pregnant	☐	Taking HRT	☐	Unexplained heavy periods	☐
Breast feeding	☐	Experiencing menopause	☐	Unexplained loss of periods	☐
Contraceptive pill	☐	Planning to have a baby	☐	Discharge from vagina	☐
IUD/implant/injection	☐	Considering infertility treatment	☐	Bleeding from vagina	☐
Have periods (menstruating)	☐	Age of first period		Perimenopause	☐
Regular well-woman checks	☐	Age of final period		Hypo Thyroid (under active)	☐
These questions are mainly for women and help your therapist target hormone and nervous system links i.e. how the body communicates				Hyper Thyroid (over active)	☐

MEN ONLY					
Acne	☐	Impotence	☐	Poor memory	☐
Altered urine flow or frequency	☐	Infertility	☐	Diminished sweating	☐
Depression	☐	Low sperm count	☐	Excessive sweating	☐
Coarse hair	☐	Low sperm motility	☐	Prostatitis	☐
Hair loss	☐	Low energy	☐	Headaches	☐
Dry skin	☐	Low mood	☐	Exposure to chemicals	☐
Cold extremities	☐	Poor concentration	☐	Swollen neck / goitre	☐

ADDITIONAL SYMPTOMS

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HEALTH SYMPTOMS

PLEASE TICK ALL APPROPRIATE SYMPTOMS

This section helps identify possible stressors in your life and the relationship with adrenal and blood glucose balance.

STRESSORS					
Changed job	☐	Unhappy at home	☐	Easily irritated	☐
Unhappy at work	☐	Recently married	☐	Easily angered	☐
Stressful hours	☐	New parents	☐	Easily satisfied	☐
Frequent travel	☐	Recently separated	☐	Excessive exercise	☐
Competitive	☐	Recently bereaved	☐	Physical injury	☐
Job promotion	☐	Moving house	☐	Physical illness	☐
Multi-tasking	☐	Financial concerns	☐	Mood swings	☐
Redundancy	☐	Legal concerns	☐	Food cravings	☐
Retirement	☐			Addictions	☐

ALLERGIES

Please list all known/suspected allergies, including food allergies and intolerances

e.g. hay-fever, dust, nickel, detergents, specific foods/food groups

EXERCISE

Do you exercise? If so what activities do you do and for what duration / how long?	How often? (how many times per week)

RELAXATION

What do you like to do to relax and how often do you do this activity?

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PERMISSION TO CONTACT GP / MEDICAL PRACTITIONER

Please note that I may contact your GP as a professional courtesy to share information and/or to inquire about test results and medications for client safety and therapeutic recommendations. It is encouraged that permission is given for this process to proceed.

	YES	NO
Permission to contact GP	☐	☐

GP Name	address	email	telephone

I confirm that I give permission to contact my GP, and for a summary of my consultation to be shared for professional courtesy and client well-being:

SIGNATURE:.....**DATE:**.....

I respect your privacy and am committed to protecting it. Sensitive personal data is collected and used in strict accordance with the new European data protection law; General Data Protection Regulation (GDPR). A copy of my privacy policy can be downloaded from the homepage of www.equilibrionutrition.com. By using my services you are agreeing to this policy.

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THREE-DAY FOOD DIARY

Please list everything you have consumed, including food, drinks and snacking between meals for a period of 3 days. Please try not to change what you eat during this period as it is more beneficial to have an accurate picture of what you typically consume.

DAY 1	QUANTITY (ESTIMATE, WEIGHT, SIZE OF PORTION EG. TSP, TBSP., GRAMS, HANDFUL)	

DAY 2	QUANTITY (ESTIMATE, WEIGHT, SIZE OF PORTION)	

DAY 3	QUANTITY (ESTIMATE, WEIGHT, SIZE OF PORTION)	

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SYMPTOMS DIARY

Please use this space to describe in your own words how you have felt in the last week, if anything has changed (for better or worse) and what, if any, impact this has had on your daily routine and mood.

HOW I FELT IN THE LAST 48 HOURS	IMPACT ON MY ROUTINE & MOOD

MYMOP (Measure Yourself Medical Outcome Profile) – To be completed during the consultation

A MYMOP is a helpful tool for monitoring symptoms between one visit and another and can be helpful for tracking progress and making adjustments to dietary and lifestyle recommendations.

1. Choose one or two symptoms (physical or mental) which bother you the most. Write them on the lines. Now consider how bad each symptom is, over the last week, and score it by circling your chosen number from 0 (good) to 6 (bad).

	As good as it could be						As bad as it could be
SYMPTOM 1	0	1	2	3	4	5	6
SYMPTOM 2	0	1	2	3	4	5	6

2. Now choose one activity (physical, social or mental) that is important to you, and that your problem makes difficult or prevents you doing. Score how bad it has been in the last week.

	As good as it could be						As bad as it could be
ACTIVITY	0	1	2	3	4	5	6

3. Lastly how would you rate your general feeling of wellbeing during the last week?

	As good as it could be						As bad as it could be
WELL-BEING	0	1	2	3	4	5	6

4. How long have you had symptom 1, either all the time or on and off?

0-4 WEEKS	4-12 WEEKS	3 MONTHS – 1 YEAR	1 – 5 YEARS	OVER 5 YEARS

5. Are you taking any medication FOR THIS PROBLEM?

YES	NO