GP | GABRIELA PEACOCK NUTRITION

NUTRITIONAL THERAPY QUESTIONNAIRE

All information will be treated as strictly confidential.

Please answer questions as accurately as you can. The information you give will help to create a tailor- made treatment protocol.

GENERAL INFORMATION

Name:	Title:

Address:	Tel.No Day:
	Mobile
	E-mail:
	Date of Birth:

Height:	Weight:

Occupation:	GP's name, address & telephone number:

CURRENT GOALS AND HEALTH CONCERNS

Please list the main health areas you would like to address.

1.

2.

3.

Do you have any special dietary requirements? Yes / No If so, what are they?

List any specific foods you avoid for personal or medical reasons.

MEDICAL HISTORY

Please list any illnesses/operations (excluding colds & flu) starting from childhood and including any current health concerns. *(Please continue on an additional sheet if necessary)*

Your health history illnesses & operations	Age of onset	Duration	Medication (include current medication)

Please specify any regular medication you may be taking: (*ie: aspirin, HRT, painkillers, contraceptive pill etc)*

Please specify if you are currently undergoing any form of medical treatment:	When did you last take antibiotics?

Are you currently taking any nutritional supplements, herbs or homoeopathic remedies? State product and daily dose:

What (if any) illnesses are present on your mothers/fathers side of the family?

If you have siblings, do they have any illnesses?

LIFESTYLE

Would you describe yourself as:

Sedentary ☐ Moderately active ☐ Active ☐ Very active ☐

What is your average intake of alcohol? (include type of alcohol, mixers etc)	Do you smoke? Yes / No
Weekday:	If so, how many per day? If you did smoke, when did you give up?
Weekend:	Any recreational drugs? If so how often/ type:

HEALTH SCREEN

If you have any of the following symptoms, please tick the box that indicates the severity of your symptoms.

1 = Mild 2 = Moderate 3 = Severe

1	2	3	**SECTION 1**
			Poor memory
			Confusion, poor comprehension
			Poor concentration
			Poor physical co-ordination
			Difficulty making decisions
			Are any of the above made worse by skipping a meal

1	2	3	**SECTION 2**
			Headache
			Faintness or dizziness
			Insomnia

1	2	3	**SECTION 3**
			Watery or itchy eyes
			Swollen, reddened, sticky eyelids
			Sensitive to bright light
			Blurred or tunnel vision (does not include near or far sight)

1	2	3	**SECTION 4**
			Itchy ears
			Earaches, ear infection
			Discharge from ear
			Ringing in ears, hearing loss

1	2	3	**SECTION 5**
			Stuffy nose or Sinus problems
			Hay fever
			Excessive mucus formation
			Sensitive to strong smells e.g. perfume, petrol, etc

1	2	3	**SECTION 6**
			Chronic cough
			Gagging
			Frequent need to clear throat
			Sore throat, hoarseness, loss of voice
			Sore tongue
			Prone to cold sores

1	2	3	**SECTION 7**
			Irregular or skipped heartbeat
			Rapid or pounding heartbeat
			Chest pain

1	2	3	**SECTION 8**
			Chest congestion/wheezing
			Asthma
			Shortness of breath
			Difficulty breathing

1	2	3	**SECTION 9**
			Nausea or vomiting
			Diarrhoea
			Constipation
			Bloated feeling
			Belching, or passing wind
			Heartburn

1	2	3	**SECTION 10**
			Acne
			Hives, rash or dry skin
			Hair loss
			Flushing or hot flushes
			Excessive sweating
			Soft, fraying or brittle nails

1	2	3	**SECTION 11**
			Water retention
			Binge eating or drinking
			Cravings for certain foods
			Lack of appetite
			Compulsive eating

1	2	3	**SECTION 12**
			Frequent illness
			Frequent or urgent urination
			General itch or discharge
			Excessive thirst
			Loss of taste or smell

1	2	3	**SECTION 13 female only**
			Menstrual pain
			Tender/painful breasts
			Mood change before period

1	2	3	**SECTION 14 male only**
			Difficulty urinating
			Loss of libido
			Mood changes

1	2	3	**SECTION 15**
			Mood swings
			Anxiety, fear or nervousness
			Anger, irritability, aggressiveness
			Depression

1	2	3	**SECTION 16**
			Fatigue, sluggishness
			Apathy, lethargy
			Hyperactivity
			Restlessness

Other symptoms: (not mentioned above including sleep patterns)

DIETARY/ LIFESTYLE ANALYSES

Do you drink normal (black) tea/ coffee? If so, how many per day?	
How many pieces of bread or any other wheat product (muffins, bagels, croissants) you eat per week?	
How many pints of milk you drink per week? Type of milk?	
How much water/ herbal tea you drink per day? (normal tea/ coffee not to be included)	
Do you eat organic food regularly?	
How many times per week you eat out?	
Do you cook/ prepare your meals?	
Do you eat live yoghurt or yogurt drinks (Yakult, Actimel)	
Do you add salt to your food?	
Do you eat whilst working or on the move? If so, how often?	
Are they any foods/ drinks you would find hard to give up?	

How many times per week you eat:			
Red meat		Smoked foods (fish, cheese, meats)	
Fish		Ready- made foods	
Poultry		Chocolate or confectionery	
Raw fruits & vegetables		Fried or flame grilled foods	

Blood sugar balance profile

Do you crave chocolate/ sweets/ starchy foods/ alcohol		Slow to wake up in the morning	
Have mood swings		Need more that 8 hours to sleep per night	
Need to eat frequently		Loss of concentration	
Experience fatigue/ energy dips during the day		Experience irritability without food	
Need coffee/ tea/ cigarette to keep you going		Excessive thirst or sweating	

Detoxification profile

Do you have (specify where needed):		*Do you (specify when necessary)*:	
Acne, itchy skin, blemishes, hives		Use sauna or steam room regularly	
High stress levels		Exercise (esp. cardio) twice or more per week	
Hormonal imbalances (PMS, menstrual or menopausal concerns)		Use any hormone- modulating medications (e.g. birth control pills, oestrogen, progesterone, prostate medications)	
Gas, bloating, nausea after fatty foods		Smoke	
Tendency to wake between 1am-3am		Consume more than 2 alcoholic beverages per day 5 or more days per week	
Sensitivity to fragrances, exhaust fumes, or strong odours		Do you feel ill after consuming garlic or onion	
History of exposure harmful chemicals (e.g. pesticides, herbicides)		Respond adversely (e.g. headaches, nausea) when you consume red wine, cheese, bananas, or chocolate	
Strong negative reactions when you consume foods/ drinks containing caffeine (e.g. insomnia, feel 'wired up', muscle pain)		Unregular bowel movements (ones every 2 or 3 days)	

FOOD DIARY

Please fill in the food diary as accurately as possible to give a guide to your typical diet.
Include a working day and a day off with **times of eating and drinking**.
Put down approximate **portion sizes** and how was the food **prepared** (fried, steamed, grilled).

Day 1	Day 2	Day3
Breakfast		
Mid- AM		
Lunch		
Mid- PM		
Dinner		
Other drinks & snacks		

ANY ADDITIONAL COMMENTS: (e.g. is the above typical of your regular diet)

Please bring this questionnaire to your consultation.

Once you have completed the questionnaire, please sign: Date:	