NUTRITION & LIFESTYLE CONSULTATION

Name:

Address:

Date of Birth:

Gender: Male / Female

Contact details: Tel: **Mobile:**

Email:

Occupation:

Height: **Weight**: **Blood Pressure if known**

Reason for consultation (aims):	
Current Health Concerns	
Health concern	Duration

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Current Medication			
Medication:	**Reason for taking**	**Duration**	**Dose**

General Information	
	Comments
Physical Appearance	
Hair (oily, thin, dry, any recent changes)	
Skin/face/neck (dry skin, oily skin, skin breakouts, eczema, glands in neck etc)	
Lips (cracks, sores, dry etc)	
Eyes (infections, dryness, eye sight etc)	
Mouth / tongue/ teeth and gums (furry, sores, bad breath etc)	
Number of mercury fillings	
Abdomen & Digestion (Bloated, constipation, fullness after eating, reflux, flatulence etc)	

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	Comments
Urination (how often in am, colour of urine) (do you get up during the night, infections etc)	
Legs and feet (varicose veins, broken veins, poor circulations, infections, fungus)	
Muscle (twitches, pain, regular pain)	
Vitality- energy levels (scale 1 low-10 high)	
Hormonal (menstrual cycle) (normal or heavy flow, regular cycle)	
Nervous system (irritability, concentration, headaches, confusion etc)	
Sleep patterns (bed before 11pm, broken sleep)	

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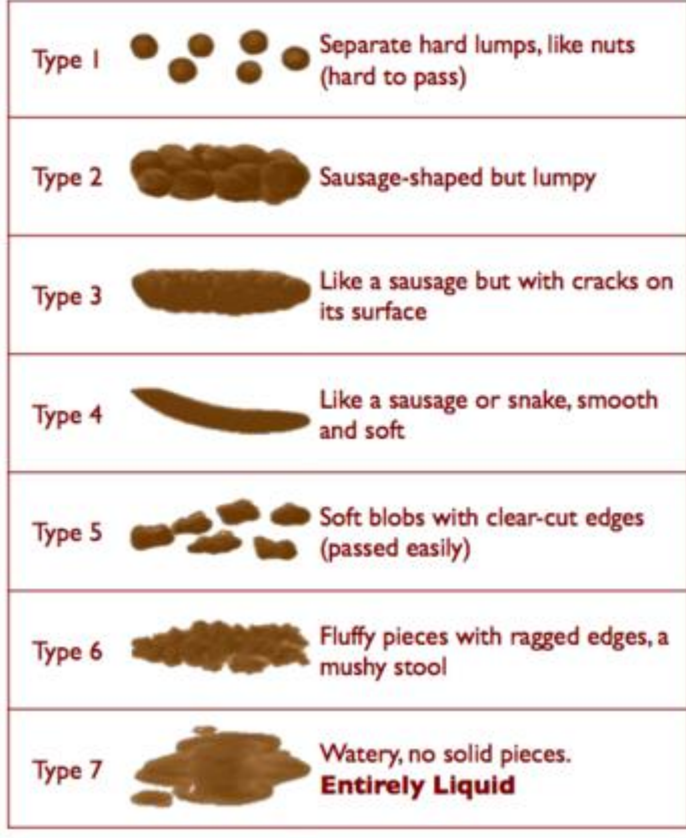
Identify your stool and urine colour

Urine Colour Chart

1	
2	
3	
4	
5	
6	
7	
8	



Detail Functional Tests	
Test	Results

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List medication used during your adult and childhood years

Medication:	Reason for taking	Year started	Duration	Dose (if known)

Please list any major accidents or operations you have had (if any):

Year	Details

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Please list (if any) nutritional supplements, herbals or homeopathic medicine that you are currently taking:

Name of supplement	Duration / reason for taking	Dosage

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Family Medical History

Mother	
Father	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

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Please list any conditions or health problems that your siblings suffer from:

Sister	**Brother**

Dietary History

Please describe any dietary restrictions that you may have
Are you allergic to any foods? Please list

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Have you been tested for these allergies? Please list method of testing and known results,		
Year	**Test**	**Known results**

Please tick cooking methods generally used?			
Boiling		Steam	
Grilling		Deep-fry	
Shallow-fry		Bake	
Roast		Microwave	
What type of fat do you usually use in cooking? Please list all used:			
Are there any foods that you would find it difficult to live without?			

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Dietary Information:

Please state how many times a day, a week or a month you eat the following foods:

Meat/Fish/Other Protein (sate which type)	
Vegetables (list examples)	
Fruit (list examples)	
Grains (List examples)	
Oils (types)	
Salt and other condiments (make a list)	
Dairy (list foods)	
Eggs	
Pulses (list types)	

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Nuts and seeds (list types)	
Convenience foods, take away, eating out	
Drinks (including soft, water, coffee, tea alcohol)	

A Typical Day (detail a typical days eating)

Meal	Time	Food and Drink Consumed (give approximate portion size)
Breakfast		
Lunch		
Dinner		
Snacks		
Condiments		

Food Likes and Dislikes:

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Lifestyle

Stress Level (on a scale of 1-10, 10 being highest)

What do you do to relieve daily stress?

Sleep Patterns: Good □ Average □ Poor □

Ability to relax: Good □ Average □ Poor □

Do you smoke or have you ever smoked:

How many units of alcohol per week:

Exercise /Activities

How long do you sit per day?

How many hours are you active per day?

What is the intensity of activity? 1 = light, 2 = moderate, 3 = heavy

Do you walk daily:	Yes □	No □
Do the gardening:	Yes □	No □
Do the cleaning/housework:	Yes □	No □
Drive everywhere:	Yes □	No □

Thank you for your time.

All information is confidential.

Signature_______________________________ Date ________________

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