



Insight Nutrition
one step closer to better health



Insight Nutrition

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Nutrition Programme Questionnaire

This questionnaire is designed to provide all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can. All details on this questionnaire will be held private and confidential

Date:

PERSONAL DETAILS

First Name: Last Name:
 Title: Date of Birth: Age:
 Address:

 Post Code: E-mail address:
 Tel (work): Tel (home):
 Tel (mobile):
 Occupation:
 Height: Weight:
 Medical Doctor's address:

Post Code: Doctor's Tel. No:
 Do you give permission for your medical doctor to be contacted? Yes No
 Is your medical doctor aware of your intention to see a nutrition consultant? Yes No
 Have you seen a nutrition consultant, or any other health professional before, regarding your symptoms? Yes No
 Have you had any blood, urine, saliva or any other laboratory tests? Yes No
 If YES please state which tests, and if possible bring a copy of the results to your consultation.

HEREDITY PROFILE

Do you have any children? If so state age and sex

 Are there any particular illnesses they suffer from?

 What illness is/was your father prone to?

Do you have and siblings? If so state age and sex

 Are there any particular illnesses they suffer from?

 What illness is/was your mother prone to?



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HEALTH PROFILE

Please state your main reason/s for seeking nutritional support

Health Problem	Duration	Management (drugs etc)/dosage
1
2
3
4
5

Under what circumstances do these symptoms improve?

Under what circumstances do they get worse?

What other illnesses have you had in the past 10 years?

What operations have you had and when?

What is your normal blood pressure? (don't worry if you don't know)

What is your resting pulse per minute?

(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found under the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds)

ADDITIONAL QUESTIONS FOR WOMEN ONLY

Do you, or have you ever taken the contraceptive pill?	Yes	No	.....
Do you, or have you ever had an IUD fitted?	Yes	No	.....
Do you, or have you ever taken HRT?	Yes	No	.....
Are your periods regular?	Yes	No	.....
Are you pre-menopausal/post-menopausal?	Yes	No	.....
Do you suffer from pre-menstrual bloatedness, tiredness, irritability, depression, breast tenderness, headaches, stomach cramps? (Please underline and add any other symptoms you experience)	.....	
Are you pregnant? If so how many weeks?	Yes	No	.....
Are you trying to become pregnant?	Yes	No	.....
Have you ever experienced a miscarriage?	Yes	No	.....
Have you ever received treatment for infertility?	Yes	No	.....
Are you considering treatment for infertility?	Yes	No	.....
Did you breast feed your infants?	Yes	No	.....

ADDITIONAL QUESTIONS FOR MEN ONLY?

Have you ever had any of the following conditions, if the condition is current please note this?

Loss of hair	Yes	No	.....
Low sperm count/motility	Yes	No	.....
Altered urine flow	Yes	No	.....
Benign prostatic hyperplasia	Yes	No	.....
Impotence	Yes	No
Infertility	Yes	No
Prostate cancer	Yes	No
Testicular cancer	Yes	No



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SYMPTOM PROFILE

Each section on this page contains a list of symptoms associated with nutritional deficiency. Please tick the conditions you suffer from. Some symptoms are repeated, 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 spasms
 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 two 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/ irritability after 6 hours without food
 Need for frequent meals
 Cold hands
 Need for excessive sleep/drowsiness during the day
 Excessive thirst
 'Addicted' to sweet food



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LIFESTYLE ANALYSIS

Cardiovascular Profile

Is your blood pressure over 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 two hours exercise a week? _____
Do you eat more than one spoon 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 beat 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) _____
Do you consider yourself fit? _____

Pollution Risk 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 (job, 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 or oz of alcohol a day? (1 glass of wine, 1 pint of beer, 1 measure of spirits)

Do you spend a lot of time in front of a TV or VDU?

Do you usually drink unfiltered 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 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, sugar containing 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 to digest fatty foods? _____
Do you occasionally use indigestion tablets? _____
Do you suffer from flatulence? _____
Do you suffer from 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 3 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 hayfever? _____
Do you suffer from allergy problems? _____
Have you had a major personal loss in the last year?



Histamine Profile

Tick the following that apply to you:

- Sleep over 8 hours
- little sex drive
- much body hair
- infrequent colds
- sluggish metabolism
- slow to wake up
- short toes and fingers
- suspicious by nature
- fat or 'well covered'
- can tolerate pain
- sleep less than 7 hours
- strong sex drive
- little body hair
- family history of allergies
- fast metabolism
- 'morning person'
- long toes and fingers
- tends towards depression
- don't put on weight, poor tolerance of pain

Allergy Profile

Tick the following that apply to you:

- Nasal problems
- hay fever
- eczema
- dermatitis
- asthma
- migraine
- irritable bowel syndrome
- frequent bloating
- facial puffiness

Do you have any allergies? Yes No
 If so what?

State type of reaction

Have they been tested? Yes No
 If so when and what type of test



DIET PROFILE

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

1. Were you breast fed?
2. Was a significant percentage of your diet as a child high in fatty foods and sugar?
3. Do you go out of your way to avoid foods containing preservatives or additives?
4. Do you avoid foods which contain sugar?
5. How many teaspoons of sugar do you add to food/drinks each day?
6. Do you use salt in your cooking?
7. Do you add salt to your food?
8. How many cups of coffee do you drink each day?
9. How many cups of tea do you drink each day?
10. How many times a week do you have meals containing fried foods?
11. How many packets of 'instant', pre-prepared or fast foods do you eat each week?
12. How many times a week do you eat chocolate or confectionary?
13. Do you wash fruit and vegetables before eating?
14. Do you normally eat white rice or brown rice? (please circle)
15. Do you normally eat white bread or wholemeal bread? (please circle)
16. Do you normally eat white pasta or wholemeal pasta? (please circle)
17. How many cans of food do you eat per week?
18. How many slices of bread or rolls do you eat each week?
19. How many pints of milk do you drink each week? Please underline type of milk drunk: full-fat, skimmed, semi-skimmed, soya, other
20. How many times a week do you eat red meat? (beef, pork, lamb or game)
21. How many times a week do you eat white meat? (chicken, turkey)
22. How many times a week do you eat fish?
23. What is your usual alcoholic drink
24. How many glasses do you drink a week?
25. How many times a week do you eat live yoghurt?
26. Do you use a water filter or drink bottled water instead of tap water?
27. Do you frequently eat under stressful conditions or on the move?
28. Does your job involve eating out a lot?
29. How would you describe your appetite?
a) poor b) average c) good

Please list any Nutritional Supplements you take on a daily basis and bring them with you.

.....

.....

.....

What food and drinks would you find hard to give up?

.....

.....

.....



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DIET PROFILE

Please write down all the foods that you consumed over the last 3 days (however, if you receive this questionnaire 3 days prior to your consultation, it will be easier to do the next 3 days). Please provide as much information as possible including quantities eaten, brand names and whether the food was fresh or packaged.

DAY 1

Breakfast

Lunch

Dinner

Snacks/Drinks

DAY 2

Breakfast

Lunch

Dinner

Snacks/Drinks

DAY 3

Breakfast

Lunch

Dinner

Snacks/Drinks
