

# HEALTH QUESTIONNAIRE

Please complete and bring with you to your first appointment

**All details on this questionnaire will be private and confidential.**

Please answer all questions as appropriate

## PERSONAL DETAILS

Date: .....

Please state: Mr  Mrs  Ms  Miss  Master  Dr  Other.....

Surname: ..... First name: ..... Marital Status: .....

Contact address: .....

..... Post code: .....

Home Tel: ..... Mobile Tel:..... Emergency contact no:.....

Date of birth: ..... Height: ..... Weight: .....

Occupation:.....

No. of dependents: ..... Age/sex of children: .....

Medical doctor's address: .....

..... Post code: ..... Doctor's Tel: .....

- Do you give permission for your medical doctor to be contacted?  for yes
- Is your medical doctor aware of your intention to see a nutritionist?
- Have you seen a nutritionist or any other health professional before regarding your current symptoms?
- Do you give permission for a student or other professional to witness your consultation?
- How did you hear about the clinic? .....
- Please state your main reason/s for seeking nutritional support .....

- |   | ✓ for yes                | If yes, please explain |
|---|--------------------------|------------------------|
| • Are you currently following a medically prescribed diet?        | <input type="checkbox"/> | .....                  |
| • Are you currently undergoing medical treatment?                 | <input type="checkbox"/> | .....                  |
| • Are you pregnant, or aiming to become pregnant?                 | <input type="checkbox"/> | .....                  |
| • Do you have a medically identified food allergy or intolerance? | <input type="checkbox"/> | .....                  |

**Please bring copies of any test results that you have had done previously.**

## MEDICATIONS and SUPPLEMENTS. Please use a separate sheet if necessary.

**Please list below any prescribed drugs** – current or in the past

Medication	Dose	Condition being treated	Frequency	Duration	current	past
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>

**Please list below any Over the Counter Medicines** – current or in the past

Medication	Dose	Condition being treated	Frequency	Duration	current	past
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>

**Please list below any vitamins, minerals, herbs and other supplements** – current or in the past

Supplement	Dose	Condition being treated	Frequency	Duration	current	past
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	.....	.....	.....	.....	<input type="checkbox"/>	<input type="checkbox"/>

# HEALTH ZONE CHECKS

## Zone 1

Thorough completion of Zone 1 enables your therapist to understand your health problems in the wider context of your family history.

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

	✓	Comments
Grandfathers	<input type="checkbox"/>	.....
Grandmothers	<input type="checkbox"/>	.....
Father	<input type="checkbox"/>	.....
Mother	<input type="checkbox"/>	.....
Brothers	<input type="checkbox"/>	.....
Sisters	<input type="checkbox"/>	.....
Sons	<input type="checkbox"/>	.....
Daughters	<input type="checkbox"/>	.....

## Zone 2

Zone 2 provides your therapist with a comprehensive picture of your health history enabling a wholistic approach to your health.

### Personal Health History

Starting with the most current health problems please list in the space provided, all significant health problems that you have encountered in your lifetime. Indicate, where appropriate, the duration, timing and management of the health problem. *Please continue on a separate sheet as necessary.*

Health Problem	Duration	Management	Date
<b>Example</b>			
Migraines	20 years	Migrileve	1982-current
Abdominal pain	2 years	Paracetamol Appendectomy	1966-1968 1968
Asthma	25 years	Ventolin Wheat-free diet	1971-1996 Jan 2000
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

## Zone 3

Zone 3 helps your therapist to identify some key symptoms that might need medical referral. This is not a definitive list. *Please tick if yes to the following questions.*

<input type="checkbox"/> any unexplained pain	<input type="checkbox"/> chest pain	<input type="checkbox"/> numbness
<input type="checkbox"/> bleeding from nipple	<input type="checkbox"/> constipation	<input type="checkbox"/> paralysis
<input type="checkbox"/> bleeding from vagina	<input type="checkbox"/> depression	<input type="checkbox"/> persistent cough
<input type="checkbox"/> blood in sputum	<input type="checkbox"/> diarrhoea	<input type="checkbox"/> persistent nose bleeds
<input type="checkbox"/> blood in stool	<input type="checkbox"/> difficulty swallowing	<input type="checkbox"/> shortness of breath
<input type="checkbox"/> blood in urine	<input type="checkbox"/> discharge from vagina	<input type="checkbox"/> slurred speech
<input type="checkbox"/> blood in vomit	<input type="checkbox"/> excessive thirst	<input type="checkbox"/> unexplained bruising
<input type="checkbox"/> blurred vision or dizziness	<input type="checkbox"/> frequent urination	<input type="checkbox"/> unexplained heavy periods
<input type="checkbox"/> breast lumps	<input type="checkbox"/> headaches	<input type="checkbox"/> unexplained loss of periods
<input type="checkbox"/> calf swelling	<input type="checkbox"/> inability to gain weight	<input type="checkbox"/> unexplained rash
<input type="checkbox"/> change in nature of moles	<input type="checkbox"/> loss of appetite	<input type="checkbox"/> unexplained weight loss

**Zone 4**

The following questions help your therapist to identify specific areas of imbalance in the body. *Please tick if yes to the following questions.*

**Weight**

- 
- fluctuating weight
- 
- 
- fast metabolism
- 
- 
- inability to gain weight
- 
- 
- inability to lose weight
- 
- 
- sudden weight loss
- 
- 
- unexplained weight loss
- 
- 
- unhappy with weight
- 
- 
- water retention
- 
- 
- weight gain:
- 
- 
- back and shoulders
- 
- 
- central
- 
- 
- hips and thighs

**Sleep**

- 
- asleep after midnight
- 
- 
- difficulty waking up
- 
- 
- disordered sleeping pattern
- 
- 
- feel sleepy during the day
- 
- 
- feel tired all the time
- 
- 
- feel un-refreshed after sleep
- 
- 
- get up after 9am
- 
- 
- insomniac
- 
- 
- need less than 7 hours sleep
- 
- 
- need more than 8 hours sleep
- 
- 
- shift worker
- 
- 
- wake up during the night

**Mood**

- 
- aggression/anger
- 
- 
- anxiety/tension
- 
- 
- apathetic
- 
- 
- competitive
- 
- 
- depression
- 
- 
- easily provoked
- 
- 
- easily satisfied
- 
- 
- frustration
- 
- 
- hyperactive
- 
- 
- irritability
- 
- 
- mood swings
- 
- 
- passive

**Energy**

- 
- best evenings
- 
- 
- best mornings
- 
- 
- difficulty getting to sleep
- 
- 
- difficulty getting up
- 
- 
- exhaustion
- 
- 
- fatigue
- 
- 
- feel tired all the time
- 
- 
- fluctuating energy
- 
- 
- hyperactivity
- 
- 
- lethargic
- 
- 
- low energy

**Digestion + Assimilation**

- 
- bloating
- 
- 
- bolt food
- 
- 
- can't tolerate fatty meals
- 
- 
- eat on the move
- 
- 
- eat when stressed
- 
- 
- flatulence
- 
- 
- heartburn
- 
- 
- indigestion
- 
- 
- pain under right rib-cage
- 
- 
- pain under right shoulder-blade
- 
- 
- reflux

**Elimination**

- 
- anal irritation
- 
- 
- blood/black stool
- 
- 
- constipation
- 
- 
- infrequent bowel action
- 
- 
- offensive stool
- 
- 
- pale, bulky stool
- 
- 
- stools that float
- 
- 
- stools that sink
- 
- 
- diarrhoea
- 
- 
- haemorrhoids
- 
- 
- mucus or pus in stool

**Inflammation**

- 
- acne
- 
- 
- arthritis
- 
- 
- asthma
- 
- 
- boils
- 
- 
- bronchitis
- 
- 
- cancer
- 
- 
- cardiovascular disease
- 
- 
- conjunctivitis
- 
- 
- Crohn's Disease
- 
- 
- cystitis
- 
- 
- dermatitis
- 
- 
- diverticulitis

- 
- eczema
- 
- 
- food allergy/intolerance
- 
- 
- gastritis
- 
- 
- gingivitis
- 
- 
- hayfever
- 
- 
- hepatitis
- 
- 
- hives
- 
- 
- IBS
- 
- 
- infections
- 
- 
- joint pains
- 
- 
- labyrinthitis
- 
- 
- mastitis

- 
- nephritis
- 
- 
- oesophagitis
- 
- 
- otitis media
- 
- 
- pancreatitis
- 
- 
- pelvic inflammatory disease
- 
- 
- prostatitis
- 
- 
- psoriasis
- 
- 
- rhinitis
- 
- 
- sinusitis
- 
- 
- SLE
- 
- 
- ulcers
- 
- 
- urethritis

**Toxic Load and Detoxification**

- 
- additives and preservatives
- 
- 
- anal itching
- 
- 
- arthritis/joint pains
- 
- 
- caffeine keeps you awake
- 
- 
- cellulite
- 
- 
- chronic allergies
- 
- 
- chronic headaches
- 
- 
- coated tongue
- 
- 
- colds/infections
- 
- 
- constipation
- 
- 
- dark circles under the eyes
- 
- 
- dark coloured urine
- 
- 
- dehydration
- 
- 
- drug use including recreational
- 
- 
- dull headaches
- 
- 
- exercise by busy main roads
- 
- 
- feeling of a hangover
- 
- 
- feel worse in damp weather
- 
- 
- high electrical exposure

- 
- high exposure domestic moulds
- 
- 
- high intake of oily fish
- 
- 
- high intake of red meat
- 
- 
- hormone problems
- 
- 
- inflammatory disorder
- 
- 
- irritability
- 
- 
- lethargy
- 
- 
- little fruit or vegetables
- 
- 
- live in a polluted environment
- 
- 
- low fibre intake
- 
- 
- low nutrient dense diet
- 
- 
- mercury fillings
- 
- 
- muscle aches
- 
- 
- nail infection
- 
- 
- offensive body odour
- 
- 
- offensive breath
- 
- 
- offensive stools
- 
- 
- offensive urine
- 
- 
- pesticide exposure

- 
- play golf regularly
- 
- 
- processed foods
- 
- 
- regular alcohol
- 
- 
- scanty urine
- 
- 
- sensitivity to chemicals
- 
- 
- signs of premature ageing
- 
- 
- smoke cigarettes
- 
- 
- thrush/athletes foot
- 
- 
- tinnitus
- 
- 
- traveller's diarrhoea
- 
- 
- unexplained itching/rashes
- 
- 
- use garden chemicals
- 
- 
- verruca/warts
- 
- 
- unwashed fruit and vegetables
- 
- 
- water retention
- 
- 
- weight loss
- 
- 
- work in a polluted environment
- 
- 
- worms or parasites
- 
- 
- yellow discolouration, skin/eyes

**Zone 5**

The following questions pertain to your allergic history and/or potential for allergy.   
 Please elaborate as appropriate and tick box if yes to the following questions.

**Comments**

- Family history of allergies .....
- Diagnosed allergy .....
- History of a severe allergic reaction .....
- Carry adrenalin injections for emergency use .....
- Hospitalised for allergies .....
- Experienced an anaphylactic shock .....
- Been tested for allergies .....

Please list the foods and/or chemicals that you react to: .....

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> aggression              | <input type="checkbox"/> fatigue            | <input type="checkbox"/> irritable bowel       | <input type="checkbox"/> poor memory        |
| <input type="checkbox"/> anxiety                 | <input type="checkbox"/> flatulence         | <input type="checkbox"/> itchy eyes            | <input type="checkbox"/> post-nasal drip    |
| <input type="checkbox"/> arthritis               | <input type="checkbox"/> fluctuating weight | <input type="checkbox"/> itchy skin            | <input type="checkbox"/> psoriasis          |
| <input type="checkbox"/> asthma                  | <input type="checkbox"/> foggy brain        | <input type="checkbox"/> itchy throat          | <input type="checkbox"/> rhinitis           |
| <input type="checkbox"/> bed-wetting             | <input type="checkbox"/> genital itch       | <input type="checkbox"/> joint aches           | <input type="checkbox"/> skin rashes        |
| <input type="checkbox"/> bloating                | <input type="checkbox"/> growing pains      | <input type="checkbox"/> learning difficulties | <input type="checkbox"/> sneezing           |
| <input type="checkbox"/> chronic diarrhoea       | <input type="checkbox"/> hayfever           | <input type="checkbox"/> lethargy              | <input type="checkbox"/> swollen lips       |
| <input type="checkbox"/> constipation            | <input type="checkbox"/> headaches          | <input type="checkbox"/> migraines             | <input type="checkbox"/> swollen throat     |
| <input type="checkbox"/> dark circles under eyes | <input type="checkbox"/> hives              | <input type="checkbox"/> mood swings           | <input type="checkbox"/> tension            |
| <input type="checkbox"/> depression              | <input type="checkbox"/> hyperactivity      | <input type="checkbox"/> mouth ulcers          | <input type="checkbox"/> tired after eating |
| <input type="checkbox"/> eczema                  | <input type="checkbox"/> indigestion        | <input type="checkbox"/> muscle aches          | <input type="checkbox"/> water retention    |
| <input type="checkbox"/> excess mucus            | <input type="checkbox"/> inflammation       | <input type="checkbox"/> palpitations          | <input type="checkbox"/> watery eyes        |
| <input type="checkbox"/> face-ache               | <input type="checkbox"/> insomnia           | <input type="checkbox"/> poor concentration    |   |

**Zone 6**

These questions are for **women only** and help your therapist specifically target any hormonal related problems.   
 Please tick if yes to the following questions.

- |  |  |
|--|--|
| <input type="checkbox"/> Are you considering infertility treatment?        | Have you ...?  |
| <input type="checkbox"/> Are you planning for a baby?                      | <input type="checkbox"/> Experienced complications in labour?    |
| <input type="checkbox"/> Are you pregnant?                                 | <input type="checkbox"/> Experienced complications in pregnancy? |
| <input type="checkbox"/> Do you have regular periods?                      | <input type="checkbox"/> Experienced difficulty breast-feeding?  |
| <input type="checkbox"/> Did you breast feed your babies?                  | <input type="checkbox"/> Experienced difficulty conceiving?      |
| <input type="checkbox"/> Do you have periods?                              | <input type="checkbox"/> Experienced normal deliveries?          |
| <input type="checkbox"/> Do you have regular well-woman check-ups?         | <input type="checkbox"/> Been diagnosed low/high thyroid?        |
| <input type="checkbox"/> Do you, or have you had an IUD fitted?            | <input type="checkbox"/> Experienced a miscarriage?              |
| <input type="checkbox"/> Do you, or have you taken the contraceptive pill? | <input type="checkbox"/> Experienced a stillbirth?               |
| <input type="checkbox"/> Do you, or have you taken HRT?                    | <input type="checkbox"/> Had a hysterectomy?                     |
| <input type="checkbox"/> Do you, or have you taken a natural HRT?          | <input type="checkbox"/> Received infertility treatment?         |
|  | <input type="checkbox"/> Taken hormones for any other reason?    |

Age of first period? ..... years old

Age of final period? ..... years old

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> acne                     | <input type="checkbox"/> excessive hair growth | <input type="checkbox"/> insomnia             | <input type="checkbox"/> poor concentration  |
| <input type="checkbox"/> bleeding from nipple     | <input type="checkbox"/> excessive sweating    | <input type="checkbox"/> irregular periods    | <input type="checkbox"/> poor memory         |
| <input type="checkbox"/> breast cancer            | <input type="checkbox"/> extreme fatigue       | <input type="checkbox"/> low body temperature | <input type="checkbox"/> protruding eyes     |
| <input type="checkbox"/> breast lumps             | <input type="checkbox"/> feel cold             | <input type="checkbox"/> low sex drive        | <input type="checkbox"/> swollen neck/goitre |
| <input type="checkbox"/> cervical cancer          | <input type="checkbox"/> fibroids              | <input type="checkbox"/> mastitis             | <input type="checkbox"/> uterine cancer      |
| <input type="checkbox"/> coarse hair/skin         | <input type="checkbox"/> fractures             | <input type="checkbox"/> mentally dull        | <input type="checkbox"/> vaginal bleeding    |
| <input type="checkbox"/> cold extremities         | <input type="checkbox"/> hair loss             | <input type="checkbox"/> osteoporosis         | <input type="checkbox"/> vaginal discharge   |
| <input type="checkbox"/> constipation             | <input type="checkbox"/> headaches             | <input type="checkbox"/> ovarian cancer       | <input type="checkbox"/> vaginal dryness     |
| <input type="checkbox"/> depression               | <input type="checkbox"/> heavy periods         | <input type="checkbox"/> ovarian cysts        | <input type="checkbox"/> vaginitis           |
| <input type="checkbox"/> difficulty losing weight | <input type="checkbox"/> high blood pressure   | <input type="checkbox"/> painful intercourse  | <input type="checkbox"/> water retention     |
| <input type="checkbox"/> diminished sweating      | <input type="checkbox"/> history of anorexia   | <input type="checkbox"/> painful periods      | <input type="checkbox"/> weight gain         |
| <input type="checkbox"/> dry hair/skin            | <input type="checkbox"/> hot flushes           | <input type="checkbox"/> PID                  | <input type="checkbox"/> weight loss         |
| <input type="checkbox"/> endometriosis            | <input type="checkbox"/> hyperactive           | <input type="checkbox"/> PMS                  |  |

**Zone 7**

These questions are for **men only** and help your therapist specifically target any hormonal related problems. *Please tick if yes to the following questions.*

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> acne                         | <input type="checkbox"/> diminished sweating        | <input type="checkbox"/> impotence           | <input type="checkbox"/> poor concentration   |
| <input type="checkbox"/> altered urine flow           | <input type="checkbox"/> dry skin, face & hands     | <input type="checkbox"/> infertility         | <input type="checkbox"/> poor memory          |
| <input type="checkbox"/> benign prostatic hyperplasia | <input type="checkbox"/> excessive sweating         | <input type="checkbox"/> infrequent shaving  | <input type="checkbox"/> prostatitis          |
| <input type="checkbox"/> benign prostatic hypertrophy | <input type="checkbox"/> feel cold                  | <input type="checkbox"/> loss of hair        | <input type="checkbox"/> prostate cancer      |
| <input type="checkbox"/> coarse hair                  | <input type="checkbox"/> headaches                  | <input type="checkbox"/> loss of hair colour | <input type="checkbox"/> protruding eyes      |
| <input type="checkbox"/> cold extremities             | <input type="checkbox"/> high exposure to chemicals | <input type="checkbox"/> low energy          | <input type="checkbox"/> swollen neck/goitre  |
| <input type="checkbox"/> depression                   | <input type="checkbox"/> hyperactive                | <input type="checkbox"/> low sperm count     | <input type="checkbox"/> testicular cancer    |
|   | <input type="checkbox"/> hypospadias                | <input type="checkbox"/> low sperm motility  | <input type="checkbox"/> undescended testicle |
|   |   | <input type="checkbox"/> mentally dull       |   |

**Zone 8**

The following questions help your therapist to identify the likelihood of adrenal and blood glucose imbalance. *Please tick if yes to the following questions.*

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> addicted to any foods  | <input type="checkbox"/> excessive thirst                | <input type="checkbox"/> impotence               | <input type="checkbox"/> panic attacks                   |
| <input type="checkbox"/> addicted to stimulants | <input type="checkbox"/> excessive urination             | <input type="checkbox"/> inflammatory disorder   | <input type="checkbox"/> poor concentration              |
| <input type="checkbox"/> anxiety/tension        | <input type="checkbox"/> feel cold                       | <input type="checkbox"/> irritability            | <input type="checkbox"/> poor co-ordination              |
| <input type="checkbox"/> blurred vision         | <input type="checkbox"/> feel faint without regular food | <input type="checkbox"/> lack of sex drive       | <input type="checkbox"/> poor memory                     |
| <input type="checkbox"/> clammy skin            |  | <input type="checkbox"/> low blood pressure      | <input type="checkbox"/> sleep more than 8 hours         |
| <input type="checkbox"/> clumsy                 | <input type="checkbox"/> fluctuating energy              | <input type="checkbox"/> low protein diet        | <input type="checkbox"/> sudden weight loss              |
| <input type="checkbox"/> depression             | <input type="checkbox"/> food allergies                  | <input type="checkbox"/> mainly refined foods    | <input type="checkbox"/> sugary foods                    |
| <input type="checkbox"/> diabetes               | <input type="checkbox"/> food cravings                   | <input type="checkbox"/> mood swings             | <input type="checkbox"/> tired, particularly after lunch |
| <input type="checkbox"/> difficulty getting up  | <input type="checkbox"/> food intolerances               | <input type="checkbox"/> nausea without food     | <input type="checkbox"/> weight gain                     |
| <input type="checkbox"/> difficulty sleeping    | <input type="checkbox"/> headaches/migraines             | <input type="checkbox"/> need for frequent meals |  |
| <input type="checkbox"/> digestive disturbance  | <input type="checkbox"/> high carbohydrate diet          | <input type="checkbox"/> osteoporosis            |  |
| <input type="checkbox"/> dizziness              | <input type="checkbox"/> hyperactivity                   | <input type="checkbox"/> palpitations            |  |

**Zone 9**

The questions in Zone 9 help your therapist identify stressors in your life. *Please tick if yes to the following questions.*

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> addicted to stimulants         | <input type="checkbox"/> exposure to chemicals    | <input type="checkbox"/> legal problems       | <input type="checkbox"/> redundancy/retirement    |
| <input type="checkbox"/> changed jobs                   | <input type="checkbox"/> exposure to pollutants   | <input type="checkbox"/> multi task           | <input type="checkbox"/> regular drug use         |
| <input type="checkbox"/> competitive                    | <input type="checkbox"/> feel too hot or too cold | <input type="checkbox"/> new parent           | <input type="checkbox"/> relax easily             |
| <input type="checkbox"/> dazzled by lights              | <input type="checkbox"/> financial loss           | <input type="checkbox"/> personal achievement | <input type="checkbox"/> shift worker             |
| <input type="checkbox"/> dizzy from sitting to standing | <input type="checkbox"/> food allergies           | <input type="checkbox"/> physical illness     | <input type="checkbox"/> unclear about your goals |
| <input type="checkbox"/> easily angered                 | <input type="checkbox"/> food intolerance         | <input type="checkbox"/> physical injury      | <input type="checkbox"/> unhappy at home          |
| <input type="checkbox"/> easily irritated               | <input type="checkbox"/> hormone imbalance        | <input type="checkbox"/> recently bereaved    | <input type="checkbox"/> unhappy at work          |
| <input type="checkbox"/> easily satisfied               | <input type="checkbox"/> inflammatory disorder    | <input type="checkbox"/> recently married     |   |
| <input type="checkbox"/> excessive exercise             | <input type="checkbox"/> insomnia                 | <input type="checkbox"/> recently moved house |   |
|   | <input type="checkbox"/> job promotion            | <input type="checkbox"/> recently separated   |   |

**Zone 10**

These questions help your therapist target the health of your circulation. *Please tick if yes to the following questions.*

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> abdominal weight gain | <input type="checkbox"/> diabetes               | <input type="checkbox"/> high fat diet               | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> anaemia               | <input type="checkbox"/> excessive exercise     | <input type="checkbox"/> high triglycerides          | <input type="checkbox"/> smoker in the past  |
| <input type="checkbox"/> angina                | <input type="checkbox"/> feel cold              | <input type="checkbox"/> lung disease                | <input type="checkbox"/> smoker now          |
| <input type="checkbox"/> arteriosclerosis      | <input type="checkbox"/> feel faint on standing | <input type="checkbox"/> minimal exercise            | <input type="checkbox"/> sugary foods        |
| <input type="checkbox"/> atherosclerosis       | <input type="checkbox"/> feel hot               | <input type="checkbox"/> nose bleeds                 | <input type="checkbox"/> thread veins        |
| <input type="checkbox"/> blood clotting        | <input type="checkbox"/> feel stressed          | <input type="checkbox"/> obesity                     | <input type="checkbox"/> varicose veins      |
| <input type="checkbox"/> blue extremities      | <input type="checkbox"/> frustrated             | <input type="checkbox"/> over-committed              | <input type="checkbox"/> water retention     |
| <input type="checkbox"/> calf pain             | <input type="checkbox"/> groin pain             | <input type="checkbox"/> pain in legs on walking     | <input type="checkbox"/> weight gain         |
| <input type="checkbox"/> chest pain            | <input type="checkbox"/> headaches              | <input type="checkbox"/> peripheral vascular disease |  |
| <input type="checkbox"/> club fingers          | <input type="checkbox"/> high blood pressure    | <input type="checkbox"/> red face                    |  |
| <input type="checkbox"/> crease in ear         | <input type="checkbox"/> high cholesterol       |  |  |

**Zone 11**

Zone 11 helps your therapist identify more about your individual body type. *Please tick if yes to the following questions.*


- |  |  |  |
|--|--|--|
| <input type="checkbox"/> allergies                     | <input type="checkbox"/> addictive/obsessive nature      | <input type="checkbox"/> abdominal pain/constipation   |
| <input type="checkbox"/> anaemia                       | <input type="checkbox"/> all boy family                  | <input type="checkbox"/> all girl family               |
| <input type="checkbox"/> blood clotting disorders      | <input type="checkbox"/> allergies                       | <input type="checkbox"/> crowded upper front teeth     |
| <input type="checkbox"/> cancer                        | <input type="checkbox"/> cry easily                      | <input type="checkbox"/> definite breath/body odour    |
| <input type="checkbox"/> chronic fatigue               | <input type="checkbox"/> depression                      | <input type="checkbox"/> depression                    |
| <input type="checkbox"/> early onset diabetes          | <input type="checkbox"/> excess salivation               | <input type="checkbox"/> difficulty remembering dreams |
| <input type="checkbox"/> heart disease                 | <input type="checkbox"/> family history of depression    | <input type="checkbox"/> early greying hair            |
| <input type="checkbox"/> inflammatory conditions       | <input type="checkbox"/> fast metabolism                 | <input type="checkbox"/> family history of depression  |
| <input type="checkbox"/> intolerant to dietary changes | <input type="checkbox"/> headaches/migraines             | <input type="checkbox"/> growing pains                 |
| <input type="checkbox"/> lupus                         | <input type="checkbox"/> little body hair                | <input type="checkbox"/> infertility/miscarriage       |
| <input type="checkbox"/> multiple sclerosis            | <input type="checkbox"/> light sleeper                   | <input type="checkbox"/> irregular periods             |
| <input type="checkbox"/> reactive immune system        | <input type="checkbox"/> long fingers and toes           | <input type="checkbox"/> morning nausea                |
| <input type="checkbox"/> sensitive digestive tract     | <input type="checkbox"/> referred itches                 | <input type="checkbox"/> pale skin                     |
| <input type="checkbox"/> ulcers                        | <input type="checkbox"/> sneeze in bright sunlight       | <input type="checkbox"/> stretch marks                 |
| <input type="checkbox"/> vulnerable immune system      | <input type="checkbox"/> tolerates pain poorly           | <input type="checkbox"/> white marks on finger nails   |
| <br>   |  |  |
| <input type="checkbox"/> broad chest                   | <input type="checkbox"/> creative                        | <input type="checkbox"/> dreams a lot                  |
| <input type="checkbox"/> curly hair                    | <input type="checkbox"/> defined moons on<br>fingernails | <input type="checkbox"/> easily aroused                |
| <input type="checkbox"/> dry warm skin                 | <input type="checkbox"/> domed forehead                  | <input type="checkbox"/> easily fatigued               |
| <input type="checkbox"/> energetic                     | <input type="checkbox"/> flat-feet                       | <input type="checkbox"/> expressive eyes               |
| <input type="checkbox"/> good sleeper                  | <input type="checkbox"/> intuitive                       | <input type="checkbox"/> fine/silky hair               |
| <input type="checkbox"/> gregarious nature             | <input type="checkbox"/> knock-knees                     | <input type="checkbox"/> fine/shapely hands            |
| <input type="checkbox"/> heavy jaw                     | <input type="checkbox"/> large head                      | <input type="checkbox"/> little body hair              |
| <input type="checkbox"/> large teeth                   | <input type="checkbox"/> large teeth                     | <input type="checkbox"/> heightened sexuality          |
| <input type="checkbox"/> little dental decay           | <input type="checkbox"/> lax joints                      | <input type="checkbox"/> long chest/long neck          |
| <input type="checkbox"/> low hair-line                 | <input type="checkbox"/> long limbs                      | <input type="checkbox"/> often dissatisfied            |
| <input type="checkbox"/> physically stocky             | <input type="checkbox"/> stimulant dependency            | <input type="checkbox"/> poor concentration            |
| <input type="checkbox"/> powerful muscle tone          | <input type="checkbox"/> strong sex drive                | <input type="checkbox"/> small, narrowly spaced teeth  |
| <input type="checkbox"/> short neck                    | <input type="checkbox"/> tall                            | <input type="checkbox"/> thin body                     |
| <input type="checkbox"/> thick or short fingers/toes   | <input type="checkbox"/> tolerates pain well             | <input type="checkbox"/> wake early and refreshed      |

**Zone 12**

Zone 12 helps your therapist identify the level of body imbalance that you are currently experiencing or have experienced in the past.

*Please tick if yes to the following questions.*

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> accidents              | <input type="checkbox"/> cirrhosis of the liver | <input type="checkbox"/> gall-bladder disease  | <input type="checkbox"/> multiple sclerosis  |
| <input type="checkbox"/> alzheimer's disease    | <input type="checkbox"/> Coeliac disease        | <input type="checkbox"/> hernia                | <input type="checkbox"/> physical handicap   |
| <input type="checkbox"/> arthritis              | <input type="checkbox"/> Chron's disease        | <input type="checkbox"/> kidney disease        | <input type="checkbox"/> thyroid overactive  |
| <input type="checkbox"/> bronchiectasis         | <input type="checkbox"/> diabetes               | <input type="checkbox"/> manic depression      | <input type="checkbox"/> thyroid underactive |
| <input type="checkbox"/> cancer                 | <input type="checkbox"/> diverticular disease   | <input type="checkbox"/> M.E.                  | <input type="checkbox"/> schizophrenia       |
| <input type="checkbox"/> cardiovascular disease | <input type="checkbox"/> emphysema              | <input type="checkbox"/> mental handicap       | <input type="checkbox"/> SLE                 |
| <input type="checkbox"/> chronic fatigue        | <input type="checkbox"/> epilepsy               | <input type="checkbox"/> motor neurone disease | <input type="checkbox"/> ulcer               |

Please indicate if you have or have had any other diagnosed health problem in the past.

.....

### Zone 13

Please answer the following questions relating your level of physical activity.

- Are you:  active\*  moderately active\*  sedentary *\*please list your activities below*
- Do you enjoy exercise? **Yes/No**
- If you do not participate in regular exercise, please indicate the factors that prevent you from doing so

Type of Exercise	Frequency	Duration	Place
.....	.....	.....	.....
.....	.....	.....	.....

### Zone 14

Zone 14 helps your therapist understand your attitudes to diet and your social circumstances in regard to food.

 

Are there any foods that you crave? .....

Are there any foods that you dislike? .....

What are your favourite foods? .....

Which foods would you find hard to give up? .....

Are you following a special diet, now or in the past?

#### Do you

- or have you experienced an eating disorder?
- cater for a special diet in the family?
- eat lots of wheat and dairy products?
- eat out frequently?
- eat when stressed?
- not avoid additives and preservatives?
- is your diet repetitive?

#### Do you

- cook for more than one?
- enjoy eating and preparing food?
- enjoy entertaining?
- have a good appetite?
- mainly purchase organic produce?
- have you recently changed your diet?
- is shopping easy for you?

### Zone 15

Completing Zone 15 helps your therapist identify the frequency of intake of specific foods and pollutants.

How many biscuits in a week? .....	How many eggs a week? .....
How many cakes/pastries in a week? .....	How many glasses of water a day? .....
How many cups of coffee a day? .....	How many raw salads in a week? .....
How many cups of tea a day? .....	How many slices of bread a day? .....
How many cigarettes a week? .....	How many tomatoes a week? .....
How many pints of milk a week? .....	How much cheese a week? .....
How many units of alcohol a week? .....	How many portions of (a portion = 80g)
How much chocolate in a week? .....	broccoli a week? .....
Quantity of red meat* in a week? .....	cabbage a week? .....
Quantity of white fish in a week? .....	carrots a week? .....
Quantity of oily fish in a week? .....	red berries a week? .....
Quantity of poultry in a week? .....	fruit a day? .....
	vegetables a day? .....

\*red meat = beef, pork, lamb and processed foods like ham, burgers and sausages

**Zone 16**

Completing Zone 16 gives your therapist a deeper insight into your current dietary choices. *Please tick if yes to the following questions.*

**Do you**

- add salt to cooking or food?
- add sugar to food or drink?
- drink tea or coffee?
- drink decaffeinated tea or coffee?
- frequently add prepared pickles and vinegar to meals?
- frequently add prepared sauces and ketchups to meals?
- mainly cook with vegetable oils?
- mainly drink tap water?
- mainly eat white bread?
- mainly use margarines?
- mainly use unrefined oils?
- regularly chew gum, toffees or sweets?
- regularly eat fried food?
- regularly eat processed food?
- regularly eat ready prepared meals?
- regularly eat salted and roasted nuts?
- regularly eat smoked and barbecued food?
- regularly eat take-away meals?
- regularly microwave food?

**Do you**

- avoid additives and preservatives?
- choose mainly low-fat food?
- dilute fruit juices?
- drink mainly bottled water?
- drink mainly filtered water?
- drink mainly organic beverages?
- eat mainly fresh fruit and vegetables?
- eat mainly organic produce?
- eat mainly wholegrain bread, pasta & cereals?
- regularly drink herbal teas?
- regularly eat beans and lentils?
- regularly eat seeds?
- use olive oil/butter for cooking?
- wash/peel chemically treated fruit and vegetables?

**Were you**

- breast-fed?
- raised on a healthy diet?

**Zone 17**

Completing Zone 17 helps your therapist understand how you put your meals together.

<b>Typical Weekday</b>	Time .....
Breakfast	
.....	
.....	
.....	
Lunch	Time .....
.....	
.....	
.....	
Dinner	Time .....
.....	
.....	
.....	
Snacks	Times of .....
.....	
.....	
Drinks	
.....	

<b>Typical Saturday</b>	Time .....
Breakfast	
.....	
.....	
.....	
Lunch	Time .....
.....	
.....	
.....	
Dinner	Time .....
.....	
.....	
.....	
Snacks	Times of .....
.....	
.....	
Drinks	
.....	

<b>Typical Sunday</b>	Time .....
Breakfast	
.....	
.....	
.....	
Lunch	Time .....
.....	
.....	
.....	
Dinner	Time .....
.....	
.....	
.....	
Snacks	Times of .....
.....	
.....	
Drinks	
.....	

<b>If you have recently changed your diet, please describe a prior typical day</b>	
Breakfast	Time: .....
.....	
.....	
.....	
Lunch	Time: .....
.....	
.....	
.....	
Dinner	Time .....
.....	
.....	
.....	
Snacks	Times of .....
.....	
.....	
Drinks	
.....	

## WHAT TO EXPECT FROM YOUR NUTRITION CONSULTATION

1. You will be sent a comprehensive case history form, which you need to fill in and bring with you for your consultation.

**Helen Williams is available on Wednesdays**

at finefettle, Rayleigh House, Unit B, 32 High Street, Bookham, Surrey KT23 4AG

2. Before your consultation, you may want a brief chat with the Nutritional Therapist –  
**Helen Williams can be contacted on her mobile phone on 07731 865141** to discuss concerns

3. Your first consultation will last for up to one and a quarter hours and costs £85. Subsequent consultations will last for up to three quarters of an hour and these cost £50. You will need to be seen again one month after your first appointment.

4. The consultation will be divided in to three parts

- (a) The clinical nutritionist will gather information;
- (b) The clinical nutritionist will come to some conclusions about what is happening to your health;
- (c) In the third part of the consultation we will come to solutions.

5. Clients will be given a hand-written note of the strategy to follow. In some cases it may be necessary for your Nutritional Therapist to write a report (if the condition needs research). This is included in the consultation fee, if a report is needed this will follow within two weeks of the date of consultation. On some occasions, the report will follow after the return of test results. Not every client will receive a full report - it is entirely at our discretion.

6. Depending on your condition, we may recommend biochemical tests.

7. We may ask you to take vitamin and mineral supplements and will design a programme for your exact needs. These can be ordered through **Nutri-link quoting ref no 503 on 08704 054 002** or the **Nutri Centre on 0845 6027 197 quoting reference ZZ HW 001**

8. After your appointment you may email **Helen Williams at [helen@surreynutritionclinic.co.uk](mailto:helen@surreynutritionclinic.co.uk)** with any concerns.

We would ask you to "Check in by email" once a week with a short progress report. You may also ring your nutritional therapist in emergencies on their mobile phones.

9. We will ask you to book a subsequent appointment for one month's time. Subsequent appointments are dependent on the condition.

10. Nutrition is a process and usually good improvement can be seen in three months – patience and the full compliance of the client is essential. Ultimately, your health is in your hands!

**Nutritional Therapy at finefettle**  
**Helen Williams – Nutritional Therapist BSc (Hons), Dip CNE, MBANT, MCNHC**

---

**Waiver**

I understand that a Clinical Nutritionist is not able to diagnose or treat medical conditions.  
Nutritional advice is not intended to replace the advice of medical doctors.  
I understand that good nutrition helps build the body's natural strength and resistance.  
I also understand that no claim is made as to the certain efficacy of any nutritional protocols. Clinical nutrition is not a substitute for the medical treatment of a doctor.  
I understand that it is advisable to inform my doctor that I am consulting a nutritional therapist. Helen Williams will only write to my doctor should I request it.

Signed.....

Date.....

(One copy of this page to be retained by Helen Williams)