PRIVATE AND CONFIDENTIAL **Date**: _____

Functional Medicine Nutritional Assessment Questionnaire

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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.

Title _____First Name_____ Last Name_____ Date of Birth_____ Age_____
Address_____
Phone numbers (home/mobile) _____ E-mail_____
Insurance Provider + Plan _____
Occupation: _____ Work environment (e.g.. city, farm)_____

Health Profile
What is your main reason for seeking nutritional advice?_____
What outcome are you hoping to achieve? _____

Please list the issues you would like to focus on. Continue on a separate sheet if you need more space.

Health issue (e.g. arthritis, overweight)	Management so far (e.g. GP, operation, exercise, paracetamol etc.)	Onset/duration
1.		
2.		
3.		
4.		
5.		

Have you had any recent health tests? Please specify or attach, if appropriate_____
_____

Have you had any other major surgery, biopsies, diagnosed medical conditions or significant periods of ill health?
(b) Do you suffer from any allergies, chronic or niggling health problems?
(Please give details e.g. high blood pressure, frequent colds, recurrent urinary infections etc.)
_____
_____

Do you suspect your symptoms relate to a particular event or time in your life?
_____

Medication & Remedies: Please list **anything you take regularly** including GP prescribed medication, self-prescribed medication (e.g. painkillers), nutritional supplements (including brand name), herbal or homeopathic remedies. Continue on a separate sheet if necessary.

Remedy/Medication/Supplement	Dose	Condition being treated	Frequency & Duration
1.			
2.			
3.			
4.			
5.			

Please state when and why you last took antibiotics plus any previous times you can remember

_____

Your vital statistics

_____What is your normal blood pressure?

_____ Your resting pulse? (take pulse seated and relaxed. Pulse can be found inside bony protuberance on thumb side of wrist)

_____ Your current weight?

_____ Your height?

_____ Your waist circumference? (if known)

_____ Your hip circumference? (if known)

_____ Your blood type? (if known)

_____ Is your weight stable, increasing or decreasing?

_____ Did you have the normal immunisations as a child?

Your family history

Do you have a family history of disease or allergies? (e.g. heart disease, diabetes, asthma, etc) State disease, age at onset, gender.

Grandfather_____

Grandmother_____

Father_____

Mother_____

Brothers/sisters_____

Children_____

Your daily life

_____Do you enjoy your daily life?

_____How many people depend on your support?

_____Do you feel supported by people around you?

_____ Are you recently separated/divorced/a new parent?

_____ Are you recently bereaved?

_____ Have you moved house or changed jobs recently?

_____ Do you work long or irregular hours?

_____ Is your workload bigger than you can manage?

_____ Are you under significant stress in any other way?

Your daily life continued

_____ Do you feel guilty when you are relaxing?

_____ Do you have a strong drive for achievement?

_____ Do you often do 2 or 3 tasks simultaneously?

_____ Do you take regular exercise?

_____ Is your job active?

_____ Do you have any active hobbies?

_____ Do you sleep well?

_____ What do you do for relaxation?

Your digestion

Do you regularly experience…

____ Indigestion (after food or between meals?)

____ Indigestion after fatty food?

____ Bowel movement shortly after eating?

_____ Frequent stomach upsets or stomach pain?

_____ Nausea or vomiting?

_____ Pain between the shoulders or under the ribs?

_____ Constipation or hard-to-pass stools?

_____ Diarrhoea or urgency to go?

_____ Blood or mucus in stools?

_____ Undigested food in stools?

_____ Stools that float

_____ Generally inconsistent bowel movements?

_____ Anal itching?

_____ Thrush or cystitis?

_____ How many bowel movements do you have in 24 hours?

_____ Have you noticed any recent change in bowel habit?

_____ Are your stools pale, mid brown, dark brown, black, grey?

Your digestion continued

_____ Have you ever had a stomach upset after foreign travel?

_____ Do any foods cause digestive problems? (which ones?)

_____ Do you chew your food thoroughly?

_____Do you regularly take antacid (indigestion) medication?

Your toxic exposure

_____ Do you live, exercise or work by a busy road?

_____ Do you spend a lot of time on busy roads?

_____ Do you live close to an agricultural area?

_____ Do you drink unfiltered water?

_____ Do you drink alcohol? If so, how many units a week?_____

_____ What is your normal alcoholic drink?

_____ Do you smoke? If so, how many a day? _____

_____ Do you live in a smoky atmosphere?

_____ Do you think you may be addicted to anything?

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

_____ Do you spend a lot of time on a mobile phone?

_____ Do you sunbathe a lot?

_____ Are you a frequent flyer?

_____ Are you exposed to chemicals through work or hobby?

_____ Do you heat, freeze or wrap food in aluminium?

_____ Roughly what percentage of your food is organic?

_____ Do you frequently fry or roast food at high temperatures?

_____ Do you regularly eat browned or barbecued foods?

_____ Do you eat oily fish or shellfish more than 3 x a week?

_____ Do you regularly consume artificial sweeteners?

_____ Do you floss your teeth regularly?

_____ Are your teeth filled with mercury amalgams?

Your energy levels

_____ Do you need more than 8 hours sleep per night?

_____ Is your energy les than you want it to be?

_____ Do you find it difficult to get going in the morning?

_____ Do you feel drowsy during the day?

_____ What time (s) of day is your energy lowest?

_____ Do you get dizzy or irritable if you don't eat often?

_____ Do you use caffeine, sugar or nicotine to keep going?

_____ Do you find it difficult to concentrate?

_____ Do you feel dizzy or light-headed if you stand up quickly?

_____ Do you suffer from unexplained fatigue or listlessness?

Women Only

_____ Are you pregnant? If so, how many weeks?

_____ Are you trying to become pregnant?

_____ Are you breast-feeding at present?

_____ How many children have you had?

_____ Have you had problems with fertility?

_____ Have you ever had a miscarriage?

_____ What contraception do you use?

_____ Are you still menstruating?

_____ Are you or have you been on HRT?

_____Are your periods regular?

_____ Any bleeding or spotting in between?

_____ Do you suffer from PCOS, fibroids, endometriosis?

_____ Any known genito-urinary conditions?

_____ Are you happy with your sex drive?

Menstruating Women: please indicate by underlining if you experience: pre-menstrual bloating, tiredness, irritability, depression, breast tenderness, water retention, headaches. Other ?

Menopausal Women: please underline if you suffer from: hot flushes, insomnia, osteoporosis, mood swings, depression, vaginal dryness. Other?

Men Only

_____ Do you experience mood swings or depression?

_____ Loss of sex drive?

_____ Loss of motivation and drive?

_____ Any known genito-urinary conditions?

_____ Fertility problems?

_____ Problems achieving or maintaining an erection?

_____ Frequent or difficult urination?

_____ Prostate problems?

_____ Wake at night to urinate?

_____ Difficult to start or stop urine stream?

_____ Pain or burning when urinating?

Diet Analysis/Eating Habits

Which are your favourite foods?

Which foods do you dislike?

Which foods do you crave?

Which foods would you find it hard to give up?

_____ Do you cater for am special diet in the household?

_____ Who does the cooking in your household?

_____ Do you avoid any food for cultural/ethical reasons?

_____ Are you allergic to any foods?

_____ Do you suspect any foods don't agree with you?

_____ Have you recently changed your diet?

_____ Do you eat on the move/when stressed?

_____Do you ever have eating binges?

_____ What do you binge on?

_____ Have you ever suffered from an eating disorder?

_____ Are you excessively thirsty?

_____ Were you breast fed?

_____Was a significant % of your diet as a child high in fatty foods and sugars?

_____ Do you eat foods containing preservatives/additives?

_____ Do you eat foods containing sugar?

_____ How many teaspoons of sugar do you add to food/drinks per day?

_____ Do you use salt in cooking/add salt to food?

_____ How many times a week do you eat chocolate, sweets, cakes and biscuits?

_____ How many pieces of raw fruit do you eat/day?

_____ how many servings of raw vegetables do you eat per day?

_____ Do you wash fruit and vegetables before eating?

_____ How many cans of food do you eat per week?

_____ Do you normally use white rice or white flour?

_____ How many slices of bread/rolls do you eat/week?

_____ How many pints of milk do you drink per week?

_____ How many times a week do you eat red meat? (beef, pork, lamb, duck or game)

_____ How many times a week do you eat white meat? (poultry, fish)

_____ How many times a week do you eat live yoghurt?

_____ Does your job involve eating out a lot?

How would you describe your appetite?

a) poor b) average c) good

Body Scan – Please UNDERLINE or HIGHLIGHT any conditions that you regularly experience

Head

Headaches, migraine, stiff neck, fuzzy headed, dizziness, poor balance, pounding head, feeling of hung over, unexplained pain

Hair

Oily, dry, poor condition, brittle, thinning, prematurely grey, dandruff, increased facial hair, increased body hair, decreased body hair

Mouth

Sore tongue, tooth decay, mouth ulcers, bad breath, sore throats, poor sense of taste, excess saliva, dry mouth, difficult swallowing, hoarse voice, gingivitis, bleeding gums, cold sores

Eyes

Burning, gritty, protruding, prone to infection, sticky, itchy, painful, poor night vision, dry, cataracts, sensitive to light, bags, swollen eyelids, blurred vision, double vision, failing eyesight, yellowish eyes

Ears

Blocked, sore, itchy, weeping, watery, overly waxy, creased earlobes

Nose

Stuffy, congested, runny, frequent nose bleeds, prone to snoring, sinusitis, hay fever, post-nasal drip, rhinitis, sneezing, poor sense of smell

Muscles

Tender, sore, cramps, spasms, twitches, loss of tone, wasting, weak, stiff, frozen, restless legs, numbness

Skin

Dry, rough, flaky, scaly, puffy, pale, brown patches, change in moles or lesions, prematurely lined, congested, oily, clammy, yellow

Skin prone to

Acne, pimples, rosacea, eczema, dermatitis, psoriasis, rashes, boils, hives, itching, stretch marks, cellulite, easy bruising, thread veins, varicose veins, ringworm, allergic reactions, excessive sweating

Joints (fingers, knees, back, shoulders etc.)

Painful, inflamed, swollen, stiff, rheumatic, arthritic, aching, sore, difficulty bending, reduced mobility, unsteadiness, slow movement

Mood

Depressed, anxious, tense, angry, happy, balanced, optimistic, sad, pessimistic, tired, can't be bothered, hyperactive, cheerful, agitated, easily upset, tearful, jittery, frightened, explosive, pent up, worried, annoyed, overwhelmed, suicidal, fluctuating, aggressive

Mind

Forgetful, difficulty learning new things, easily confused, difficulty concentrating, easily frustrated, easily distracted, difficult to make decisions, can't switch off, loss of interest in daily life, fogginess, dyslexia, dyspraxia, hyperactive, panic attacks, no motivation

Chest

Frequent colds and chest infections, asthma, bronchitis, diagnosed heart condition, palpitations, chest discomfort/pain, short of breath, difficulty breathing, wheezing, persistent cough, noisy breathing

Gut

Bloated, tender, cramping, distended, nausea, sensation of fullness, acid reflux, heartburn, flatulence, belching, churning, painful, irritable bowel syndrome, celiac, hiatus hernia, diverticula, polyps, haemorrhoids, ulcers, sluggish, sensitive, constipation, diarrhoea

Genitals

Itchy, cystitis, thrush, ulcers, warts, herpes, groin pain, prostatitis, pelvic inflammatory disease, impotence, painful intercourse, vaginal dryness, painful or frequent urination, unexplained discharge

Hands

Dry, cracked, eczema, sore joints, puffy, cold, chilblains, numbness, tingling, feel clumsy & uncoordinated, poor circulation

Nails

Fragile, dry, brittle, flaky, peeling, splitting, hangnails (split cuticles), ridged, spoon shaped, white spots on more than 2 nails, horizontal white lines, thickened or 'horny', dark nails, pale nail bed, infected

Legs & Feet Restless legs, swollen, aching, athlete's foot, fungal nails, burning feet, tender heels, gout, sciatica, cold feet, tingling, numb, prickling

IMPORTANT SYMPTOMS – may require additional medical care (please underline any that you may suffer from)
Persistent or unexplained pain, unexplained bleeding or discharge from nipple, vagina or rectum, blood in sputum, vomit, urine or stools, breast lumps, calf swelling, difficulty swallowing, excessive thirst, increased urination, inability to gain or lose weight, loss of appetite, paralysis, slurred speech, unexplained bruising, rash or weight loss, black tarry stools, painless ulcers or fissures, bleeding in pregnancy.

Your Health Carers: What is your GP's Name?_____
GP's Address: _____
GP's Phone Number: _____

Any other therapists/clinic involved in your care? Please list: _____
_____

Is this your first visit to a Nutritional Therapist? _____How did you find out about me? _____

CONSENT TO TREATMENT:

1. I understand that Kyrin Hall is a Licensed Nutritional Therapist.

2. I understand that Kyrin Hall will use only natural, non-invasive methods of assessment and treatment.

3. I understand that any therapies recommended will be explained to me in full and that I will give consent to treatment based on informed consent.

4. I understand that I am at liberty to seek, or to continue medical care with another health care provider.

5. I understand that Kyrin Hall reserves the right to determine which cases fall outside of her scope of practice, and an appropriate referral will be recommended.

6. I understand that I am accepting or rejecting this care by my own free will.

7. I understand that the services offered here may only be partially covered by health insurance, and I agree to pay the fees for services, prescriptions, and laboratory tests at the time of the appointment.

9. I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee of €70.

10. I have disclosed all the relevant information applicable to this consultation and my health status at this point in time.

11. I consent for the information to be used by my Nutritional Therapist to liaise with other health professionals concerning my care, if appropriate. I will be advised beforehand.

_____ **Initial here**
I _____ have read, understood and agree to the above statements.
Signature_____ Date _____

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3-Day Lifestyle Diary

Name_____ Date_____

Please choose ***2 fairly typical weekdays and a weekend or 'day off'*** and record as much as you can about your eating, sleep and leisure patterns on the page below. Please give as much information as possible – home cooked or not, brand names, fresh, packaged, whole, refined, organic etc. to help build an accurate picture of your lifestyle.

	Weekday 1	**Weekday 2**	**Day Off**
B'fast	**Time:**	**Time:**	**Time:**
Lunch	**Time:**	**Time:**	**Time:**
Dinner	**Time:**	**Time:**	**Time:**
Snacks	**Times:**	**Times:**	**Times:**
Drinks	__coffees (__sugars/cup) __'normal' tea (sugars/cup) __green/herbal tea __fizzy drinks/cordial __units of alcohol __glasses of water other drinks__	__coffees (__sugars/cup) __'normal' tea (sugars/cup) __green/herbal tea __fizzy drinks/cordial __units of alcohol __glasses of water other drinks__	__coffees (__sugars/cup) __'normal' tea (sugars/cup) __green/herbal tea __fizzy drinks/cordial __units of alcohol __glasses of water other drinks__

Your Routine – Please choose ***2 fairly typical weekdays and a weekend or 'day off'*** and record as much as you can about your sleep and leisure patterns.

	Day 1	**Day 2**	**Day Off**
Wake up time			
Get up time			
Work day start time			
Work day breaks (total hrs)			
Work day end time			
Time spent travelling			
Time spent exercising			
Type of exercise			
Exercise time of day			
Time spent relaxing			
Type of relaxation			
Other leisure activity			
Other routine			
Energy low times			
Overall mood			
Go to bed time			
Fall asleep time			
Uninterrupted sleep?	**Y/N?**	**Y/N?**	**Y/N?**