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Strictly Private and Confidential

Your health and well being are influenced by many factors. In order to find the best nutrition style for you it is important I know as much as possible about your lifestyle, family and health history, and eating habits. Please complete the following questionnaire.

New Patient Nutrition Assessment Form

Title:	Name:	Surname:	
Address:		Contact Tel. No:	
		Email:	
Please indicate your preferred method of contact:		Phone	Email
Height:	Weight: Min weight: Max weight:		Date of Birth:
Sex: M F	Children:	Occupation:	
GP name and address:	Other doctors or practitioners you see:		Permission to contact you GP/medical consultant if necessary: Yes/No
Date of last physical exam/blood test:		Are you pregnant? Yes/No Due Date?	
SIGNATURE:		**DATE:**	

Goals

List your food and nutrition-related goals:
1)

2)

3)

Do you feel anxious about changing your diet? Yes/No	Do you feel anxious about changing your lifestyle? Yes/No

Please indicate your willingness to take the following actions in order to reach your nutrition related goals on a scale of 1 (not willing) to 5 (very willing):

	1	2	3	4	5
Modify your diet significantly					
Increase water intake					
Modify your lifestyle (i.e exercise, sleep habits, physical activities)					
Keep a diet diary					
Take nutritional supplements if necessary					
Learn more about healthy diet					

Past Medical History and Family History

Please indicate weather you or your close relatives (grandparents/parents/siblings) have been diagnosed with any of the following diseases:

Disease	Self	Relative	Age diagnosed
Asthma			
Allergies (food/drug/other)	Please specify type:	Please specify type:	
High blood pressure (hypertension)	Please specify your usual b/p:		
Heart disease/Angina/Heart attack	Please specify:	Please specify:	
Skin condition (eczema/psoriasis/dermatitis/ rashes/sensitivity)	Please specify type:	Please specify type:	
Rheumatoid Arthritis			
Osteoarthritis			
Diabetes Type I/ Type II			
Glucose Intolerance			
Kidney stones/Kidney failure			
Liver/Gallbladder disease/Hepatitis	Please specify:	Please specify:	
Cancer	Please specify type:	Please specify type:	
Depression			
Anxiety/Panic Attacks			
Crohn's Disease/Ulcerative Colitis			
Insomnia			
Osteoporosis			
Chronic Fatigue Syndrome			
Injuries	Please specify type:	Please specify type:	
Operations	Please specify type:	Please specify type:	
Gastrointestinal conditions (gastritis, ulcers, heartburn, irritable bowel syndrome, constipation et.c)	Please specify:	Please specify:	
Gout			
Thyroid disease	Please specify:	Please specify:	
Epilepsy			
Other:	Please specify:	Please specify:	

Have you ever had any of the following:

High blood sugar	Yes/No
High blood fats (cholesterol, triglycerides)	Yes/No
High blood pressure	Yes/No
Low blood sugar	Yes/No
Abnormal thyroid tests	Yes/No
Abnormal hormone tests	Yes/No
Low hemoglobin levels (anemia)	Yes/No
Coagulation problems	Yes/No
Abnormal urine test	Yes/No

Have you ever had (only for women):		Have you ever had (only for men):	
PMS	Yes/No	Prostate problems	Yes/No
Fertility problems	Yes/No	Fertility problems	Yes/No
Polycystic Ovarian Syndrome	Yes/No	Erectile disfunction	Yes/No
Irregular menstrual cycle	Yes/No		

Please complete the following information concerning your family's history

	Age	If living: health state	If deceased: cause of death
Mother			
Father			
Siblings			

Please rate each of the following symptoms for the past 30 days (0-never/almost never have; 1-occasionally have it; 2-frequently have it)

Frequent colds ___	Poor memory ___	Shortness of breath ___	Bladder Infection ___	Nausea/Vomiting ___
Allergies ___	Poor concentration ___	Difficulty breathing ___	Kidney problems ___	Diarrhea ___
Fatigues ___	Dizziness ___	Blood in stool ___	STD ___	Constipation ___
Insomnia ___	Apathy ___	Blood in urine ___	Burning urination ___	Bloating ___
Headaches ___	Hyperactivity ___	Chest pain ___	Cystitis ___	Heartburn/Reflux ___
Ear Infections ___	Sore throat ___	Irregular heartbeat ___	Excessive hair growth__	Hemorrhoids ___
Ringing in Ears ___	Mouth ulcers ___	Fainting spells ___	Excessive sweating ___	Stomach pains ___
Blurred Vision ___	Chronic cough ___	Rapid heartbeat ___	Nose bleedings ___	Pains in abdomen ___
Itchy/red eyes ___	Sinus problems ___	High blood pressure ___	Dry/sensitive skin ___	Intestinal spasms ___
Bags under eyes ___	Excessive mucus ___	Low blood pressure ___	Hot flashes ___	Belching ___
Binge eating ___	Joint pains/aches ___	Mood swings ___	Acne ___	Hay fever ___
Cravings ___	Stiffness ___	Anxiety/fear ____	Hair loss ___	Cold sores ___
Weight loss ___	Muscle pains/aches ___	Anger/Aggression ___	Fungal infection ___	Asthma ___
Weight gain ___	Red/swollen joints ___	Depression ___	Hives/rashes ___	Lung infection ___
Weight fluctuates___	Back/Neck pains ___	Learning difficulties ___	Brittle nails ___	Water retention ___

Are you allergic to any medication (if yes, specify)?	
When did you last take antibiotics?	

Your Diet, Eating habits, and Lifestyle

Your eating style (check all that apply):

Fast Eater	Enjoy cooking
Eat more/less when stressed	Do not like cooking
Eat more/less when bored	Do not have time for cooking
Eat more/less when excited	Often skip meals
Eat too much	Late night-eater
Eat too little	Skip breakfast
Love to eat	Skip lunch
Eat fast food frequently	Do not eat after 6PM
Crave sweets/chocolate	Do not plan menus
Drink very little water	Plan meals in advance
Drink much coffee/black tea	Like herbal teas
Drink fizzy drinks/sweet drinks regularly	Have to cook for family members with different tastes
Dislike healthy food	
Poor snack choice	Confused about nutrition
Eat because I have to	Follow “fast-result” diets

What foods do you crave if any?

What foods do you avoid if any? Please specify the reason (religious, cultural, don't like how it tastes, health concerns et.c)

Do you have any food allergies, intolerances, sensitivities? Please, list all past an present

Where do you usually shop for food?

Do you find home cooking difficult? Yes/No
Do you like cooking? Yes/No
Do you snack? Yes/No
Do you skip meals? Yes/No
Do you want to change any of your eating habits? Yes/No
Have you ever been to a Nutritionist/Nutrition Therapist/Dietitian? Yes/No
If yes, please provide additional information

Beverage summary: please fill the table below indicating beverages you drink usually

Beverage	Type (circle all that apply)	Amount
Water	Tap/Bottled Still/Sparkling/Flavored	_____ glasses per day OR _____ liters per day
Coffee	Black/White/Decaf Single/Double With sugar/No sugar	_____ cups per day OR _____ cups per week Size of a cup: small/medium/large
Tea	Black/Green/Herbal With milk/No milk With sugar/No sugar	_____ cups per day OR _____ cups per week Size of a cup: small/medium/large
Juice	Freshly squeezed/Shop bought Fruit/Vegetable/Mixed	_____ glasses per day OR _____ glasses per week
Soda	Regular/Diet	_____ glasses per day OR _____ glasses per week
Alcohol	Beer/Red wine/White wine/Spirits	_____ glasses per day OR _____ glasses per week OR _____ glasses per month Size of a glass: 125ml/250ml/500ml

Food intake summary: please fill the table below indicating the frequency that you eat the following:

Food	**How often do you eat it:**			
	Every day	Every week	Every month	Several times a year/Never
Fast food				
Restaurant/Cafe food				
Home cooked food				
Ready to eat meals				
Red meat				
Poultry				
Fish				
Vegetables				
Fruits				
Berries				
Nuts/Seeds				
Milk, Cheese, Butter				
Yoghurt, Cottage cheese				
Soyfoods				
Beans				
Grains				
Canned food				
Mushrooms				

What is your physical activity?

Type:	**Duration/Intensity:**	**# Days per week:**
Cardio/Aerobics (specify)		
Strength training (specify)		
Sports (specify)		
Dancing (specify)		
Yoga/Stretching		

Do you enjoy physical activities? Yes/No
How would you rate daily stressors in your life from 1 (very low) to 10 (extremely high)?
What helps you to relax?

You normally go to bed _____? Fall asleep _____? Wake up _____?
Do you wake up during the night? Yes/No

Do you smoke? Yes/No
If Yes, how many cigarettes per day do you smoke?

Do you currently use or have you ever been using drugs? Yes/No
If Yes, please specify the drug you use and for how long do you use/used it?

Are you currently on any medication? Yes/No
If Yes, please fill the table below:

Medication	Dose (Units)	Frequency	Condition
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.			

Are you currently on any supplement? Yes/No
If Yes, please fill the table below:

Medication	Dose (Units)	Frequency	Condition
1. 2. 3. 4. 5. 6. 7. 8. 9. 10.			

ADDITIONAL INFORMATION: