

# t r i -nutrition nutrition & health profile

## All details are private and confidential

Please complete this questionnaire comprehensively to enable your nutritional therapist to build an individualised nutritional programme.

Date completed: \_\_\_\_\_

### personal details

Name: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Post code: \_\_\_\_\_ Home Tel: \_\_\_\_\_

Mobile Tel: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

GP's Name & address: \_\_\_\_\_

\_\_\_\_\_ Post code: \_\_\_\_\_ Doctor's Tel: \_\_\_\_\_

Are you currently seeing any other health or complementary health professional? Yes/No

• Do you give permission for your General Practitioner to be contacted? Yes / No

Please state your main reason/s for seeking nutritional support and what you hope to gain in the short and long term?

### personal health history

Please specify all significant health problems/operations both current and past and their duration starting with the most recent. Please list all current medications and doses including all over the counter medications, such as antacids.

*Please continue on a separate sheet as necessary.*

Health Problem	Duration	Management	Date
<b>Example</b> Migraines	20 years	Migrileve	1982-current
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Supplement	Dose	Reason	Frequency	Duration	current	past
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

# Heredity profile

Age/sex of any children: \_\_\_\_\_ Age/sex of siblings: \_\_\_\_\_

Please indicate if any of the following occur in your family

	maternal side	paternal side	siblings	children	self
Addictive/obsessive					
Alzheimer's disease					
Heart & circulation problems					
Asthma					
Attention deficit/ Hyperactive/learning difficulties					
Autism					
Cancer					
Allergies/sensitivities/intolerances					
Chronic fatigue					
Coeliac disease					
Constipation					
Depression					
Diabetes (type 1/type 11)					
Eczema					
Endometriosis					
Epilepsy					
Fibroids					
Hayfever					
Headaches/migraines					
High blood pressure					
High cholesterol					
Recurrent infections					
Infertility/miscarriages					
Insomnia					
Irritable bowel					
Rheumatoid/osteoarthritis					
Osteoporosis					
Thyroid imbalance					
Overweight					
Parkinson's disease					
Polycystic ovaries					
Mood disorders/schizophrenia					
Other					

Please specify if your parents and grandparents are alive and their state of health:

## Symptom analysis

Below is a list of symptoms associated with nutritional deficiencies. Underline the conditions from which you often suffer. Some symptoms are repeated – please underline them each time they occur.

Acne  
Dandruff  
Dry flaky skin  
Frequent colds or infections  
Mouth ulcers  
Poor night vision  
Thrush or cystitis

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Constipation  
Eye pains irritability  
Poor concentration  
Poor memory  
Prickly legs  
Rapid heart beat  
Stomach pains  
Tender muscles  
Tingling hands

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Burning or gritty eyes  
Sensitivity to bright lights  
Sore tongue  
Cataracts  
Dull or oily hair  
Eczema or dermatitis  
Split nails  
Cracked lips

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Lack of energy  
Diarrhoea  
Insomnia  
Headaches or migraine  
Poor memory  
Anxiety or tension  
Depression  
Irritability  
Bleeding or tender gums  
Acne

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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

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Infrequent dream recall  
Water retention  
Tingling hands  
Depression or nervousness  
Irritability  
Muscle tremors or cramps  
Lack of energy  
Flaky skin

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Tingling sensations  
Poor hair condition  
Eczema or dermatitis  
Mouth over sensitive to hot or cold  
Irritability  
Anxiety or tension  
Lack of energy  
Constipation  
Tender or sore muscles  
Pale skin

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Eczema  
Cracked lips  
Prematurely greying hair  
Anxiety or tension  
Poor memory  
Lack of energy  
Poor appetite  
Stomach pains

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Dry skin  
Poor hair condition  
Prematurely greying hair  
Tender or sore muscles  
Poor appetite or nausea  
Eczema or dermatitis

---

Frequent colds  
Lack of energy  
Frequent infections  
Bleeding or tender gums  
Easy bruising  
Nose bleeds  
Slow wound healing  
Red pimples on skin

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Back ache  
Excessive sweating  
Hair loss  
Joint pain or stiffness  
Lack of energy  
Muscle cramps or spasms  
Rheumatism or arthritis  
Tooth decay

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Lack of sex drive  
Exhaustion after light exercise  
Easy bruising  
Slow wound healing  
Varicose veins  
Loss of muscle tone  
Infertility

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Dry, rough skin  
Dry eyes  
Frequent infections  
Poor memory  
Loss of hair or dandruff  
Excessive thirst  
Poor wound healing  
PMS or breast pain  
Infertility

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Muscle tremors or spasms  
Muscle weakness  
Insomnia or nervousness  
High blood pressure  
Irregular heart beat  
Constipation  
Fits or convulsions  
Hyperactivity  
Depression

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Muscle cramps or tremors  
Insomnia or nervousness  
Joint pain or arthritis  
Tooth decay  
High blood pressure

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Pale skin  
Sore tongue  
Fatigue or breathlessness  
Loss of appetite or nausea  
Heavy periods or blood loss  
Itching  
Dull hair  
Hair loss

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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

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Muscle twitches  
Childhood 'growing pains'  
Dizziness or poor sense of balance  
Fits or convulsions  
Sore knees

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Family history of cancer  
Signs of premature ageing  
Cataracts  
High blood pressure  
Frequent infections

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Excessive or cold sweats  
Dizziness or irritability after 6 hours without food  
Need for frequent meals  
Cold hands  
Need for excessive sleep or drowsiness during the day  
Excessive thirst  
'Addicted' to sweet foods

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# Lifestyle & system analysis

## sleep & energy profile

How do you sleep?

## weight profile

Are you happy with your weight?

## mood profile

What are your moods like?

Please tick boxes if you experience any of the following :

### digestion & elimination profile

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> bloating                   | <input type="checkbox"/> pain under right rib-cage       | <input type="checkbox"/> infrequent bowel action         |
| <input type="checkbox"/> bolt food                  | <input type="checkbox"/> pain under right shoulder-blade | <input type="checkbox"/> offensive, pale and bulky stool |
| <input type="checkbox"/> can't tolerate fatty meals | <input type="checkbox"/> reflux/heartburn                | <input type="checkbox"/> diarrhoea                       |
| <input type="checkbox"/> eat when stressed          | <input type="checkbox"/> anal irritation                 | <input type="checkbox"/> haemorrhoids                    |
| <input type="checkbox"/> flatulence                 | <input type="checkbox"/> blood/black stool               | <input type="checkbox"/> mucous or pus in stool          |
| <input type="checkbox"/> indigestion                | <input type="checkbox"/> constipation                    |  |

### pollution and toxic load profile

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> caffeine keeps you awake        | <input type="checkbox"/> live in a polluted environment | <input type="checkbox"/> sensitivity to chemicals |
| <input type="checkbox"/> coated tongue                   | <input type="checkbox"/> work in a polluted environment | <input type="checkbox"/> smoke cigarettes         |
| <input type="checkbox"/> dark coloured urine             | <input type="checkbox"/> mercury fillings               | <input type="checkbox"/> use garden chemicals     |
| <input type="checkbox"/> drug use including recreational | <input type="checkbox"/> offensive urine                | <input type="checkbox"/> alcohol                  |
| <input type="checkbox"/> dull headaches                  | <input type="checkbox"/> play golf regularly            | <input type="checkbox"/> dark rings under eyes    |
| <input type="checkbox"/> exercise by busy main roads     |   |   |
| <input type="checkbox"/> feeling of a hangover           |   |   |

### allergy profile

- Diagnosed allergy
- History of a severe allergic reaction/epipen/hospitalised
- Been tested for allergies

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

- |                                       |  |
|---------------------------------------|--|
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> IBS                   |
| <input type="checkbox"/> eczema       | <input type="checkbox"/> itchy eyes            |
| <input type="checkbox"/> excess mucus | <input type="checkbox"/> itchy skin            |
| <input type="checkbox"/> foggy brain  | <input type="checkbox"/> itchy throat          |
| <input type="checkbox"/> genital itch | <input type="checkbox"/> joint aches           |
| <input type="checkbox"/> hayfever     | <input type="checkbox"/> learning difficulties |
| <input type="checkbox"/> headaches    | <input type="checkbox"/> migraines             |

### comments

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- |   |   |
|---|---|
| <input type="checkbox"/> mood swings        | <input type="checkbox"/> skin rashes          |
| <input type="checkbox"/> mouth ulcers       | <input type="checkbox"/> swollen lips         |
| <input type="checkbox"/> palpitations       | <input type="checkbox"/> swollen throat       |
| <input type="checkbox"/> poor concentration | <input type="checkbox"/> tired after eating   |
| <input type="checkbox"/> poor memory        | <input type="checkbox"/> water retention      |
| <input type="checkbox"/> post-nasal drip    | <input type="checkbox"/> watery eyes          |
| <input type="checkbox"/> psoriasis          | <input type="checkbox"/> were you breast fed? |
| <input type="checkbox"/> sneeze a lot       |   |

### female hormonal profile

- |   |  |
|---|--|
| <input type="checkbox"/> Are you planning for a baby or pregnant?       | <input type="checkbox"/> Do you have endometriosis?                  |
| <input type="checkbox"/> Do you have periods? Regular/irregular         | <input type="checkbox"/> Do you have excessive hair growth?          |
| <input type="checkbox"/> Do you have painful periods?                   | <input type="checkbox"/> Do you, or have you taken HRT/natural HRT?  |
| <input type="checkbox"/> Are your periods heavy/normal/scant?           | <input type="checkbox"/> Do you experience hot flushes/night sweats? |
| <input type="checkbox"/> Do you have regular well-woman check-ups?      |  |
| <input type="checkbox"/> History of miscarriage?                        |  |
| <input type="checkbox"/> Any indication of osteoporosis?                |  |
| <input type="checkbox"/> Been diagnosed with low/high thyroid?          |  |
| <input type="checkbox"/> Do you experience breast pain/lumps?           |  |
| <input type="checkbox"/> Do you, or have you had an IUD fitted/the pill |  |

*If you have had children please answer:*

- Experienced complications in labour?
- Experienced complications in pregnancy?
- Experienced fertility problems?
- Experienced normal deliveries?

Age of first period? \_\_\_\_\_ years old

Age of final period? \_\_\_\_\_ years old

### male profile

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> altered urine flow | <input type="checkbox"/> Mood swings or depression                       | <input type="checkbox"/> Do you need to eat frequently        |
| <input type="checkbox"/> enlarged prostate  | <input type="checkbox"/> Any known genital-urinary conditions            | <input type="checkbox"/> Experience drowsiness during the day |
| <input type="checkbox"/> Impotence          | <input type="checkbox"/> Do you crave sweet or starchy food              |   |
| <input type="checkbox"/> Low sperm count    | <input type="checkbox"/> Are you irritable without food                  |   |
| <input type="checkbox"/> Low sperm motility | <input type="checkbox"/> Are you slow to wake up                         |   |
| <input type="checkbox"/> Prostatitis        | <input type="checkbox"/> Do you need coffee, tea, cigarette to get going |   |

### adrenal and blood glucose profile

Are you/or do you have ...

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> addicted to stimulants   | <input type="checkbox"/> excessive thirst                       | <input type="checkbox"/> impotence          | <input type="checkbox"/> need for frequent meals         |
| <input type="checkbox"/> blurred vision           | <input type="checkbox"/> excessive urination                    | <input type="checkbox"/> irritability       | <input type="checkbox"/> panic attacks                   |
| <input type="checkbox"/> clammy skin              | <input type="checkbox"/> feel cold                              | <input type="checkbox"/> lack of sex drive  | <input type="checkbox"/> tired, particularly after lunch |
| <input type="checkbox"/> clumsy/poor coordination | <input type="checkbox"/> feel faint/nausea without regular food | <input type="checkbox"/> low blood pressure |  |
| <input type="checkbox"/> diabetes                 | <input type="checkbox"/> food cravings                          | <input type="checkbox"/> palpitations       |  |
| <input type="checkbox"/> dizziness                |   | <input type="checkbox"/> mood swings        |  |

### stress profile

In the last five years have you experienced/or are you....

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Addicted to stimulants    | <input type="checkbox"/> Exercise excessively | <input type="checkbox"/> Over-committed          | <input type="checkbox"/> Redundancy/retirement |
| <input type="checkbox"/> Changed jobs              | <input type="checkbox"/> Job promotion        | <input type="checkbox"/> New parent              | <input type="checkbox"/> Moved house           |
| <input type="checkbox"/> Dazzled by lights         | <input type="checkbox"/> Legal problems       | <input type="checkbox"/> Physical illness/injury | <input type="checkbox"/> Married/divorced      |
| <input type="checkbox"/> Dizzy sitting to standing | <input type="checkbox"/> Multi task           | <input type="checkbox"/> Bereaved                | <input type="checkbox"/> Unhappy at home/work  |

What do you do to manage stresses? \_\_\_\_\_

### circulation profile

Which if any of the following apply....

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> diagnosed anaemia  | <input type="checkbox"/> feel cold/hot           | <input type="checkbox"/> nose bleeds              | <input type="checkbox"/> thread veins    |
| <input type="checkbox"/> diagnosed angina   | <input type="checkbox"/> high/low blood pressure | <input type="checkbox"/> obesity                  | <input type="checkbox"/> varicose veins  |
| <input type="checkbox"/> blood clotting     | <input type="checkbox"/> high cholesterol        | <input type="checkbox"/> pain in legs on walking  | <input type="checkbox"/> water retention |
| <input type="checkbox"/> blue extremities   | <input type="checkbox"/> high fat diet           | <input type="checkbox"/> red face                 |  |
| <input type="checkbox"/> calf pain          | <input type="checkbox"/> high triglycerides      | <input type="checkbox"/> shortness of breath      |  |
| <input type="checkbox"/> chest pain         | <input type="checkbox"/> diagnosed lung disease  | <input type="checkbox"/> smoker in the past/now   |  |
| <input type="checkbox"/> diagnosed diabetes |  | <input type="checkbox"/> eat lots of sugary foods |  |

### Inflammation profile

- |  |  |                                      |  |
|--|--|--------------------------------------|--|
| <input type="checkbox"/> Acne            | <input type="checkbox"/> Cystitis/Urethritis | <input type="checkbox"/> Hayfever    | <input type="checkbox"/> Labyrinthitis       |
| <input type="checkbox"/> Arthritis       | <input type="checkbox"/> Dermatitis          | <input type="checkbox"/> Herpes      | <input type="checkbox"/> Mastitis            |
| <input type="checkbox"/> Asthma          | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Nephritis           |
| <input type="checkbox"/> Boils           | <input type="checkbox"/> Food Allergy        | <input type="checkbox"/> Hives       | <input type="checkbox"/> Oesophagitis        |
| <input type="checkbox"/> Bronchitis      | <input type="checkbox"/> Food Intolerances   | <input type="checkbox"/> IBS         | <input type="checkbox"/> Otitis Media        |
| <input type="checkbox"/> Crohn's disease | <input type="checkbox"/> Gastritis           | <input type="checkbox"/> Infection   | <input type="checkbox"/> Pancreatitis        |
| <input type="checkbox"/> Conjunctivitis  | <input type="checkbox"/> Gingivitis          | <input type="checkbox"/> Joint Pains | <input type="checkbox"/> Pelvic inflammation |
| <input type="checkbox"/> Prostatitis     | <input type="checkbox"/> Rhinitis            | <input type="checkbox"/> SLE         | <input type="checkbox"/> Ulcers              |
| <input type="checkbox"/> Psoriasis       | <input type="checkbox"/> Sinusitis           |                                      |  |

### exercise profile

- Are you...  active\*  moderately active\*  sedentary \*please list your activities below
- Do you enjoy exercise? **Yes/No**
- Do you do any vigorous exercise, e.g. gardening, walking fast, gym, rowing etc?
- Activities \_\_\_\_\_

### Histamine/histapaenic/pyroluric profile

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> addictive/obsessive nature | <input type="checkbox"/> excess salivation            | <input type="checkbox"/> light sleeper             |
| <input type="checkbox"/> all boy family             | <input type="checkbox"/> family history of depression | <input type="checkbox"/> long fingers and toes     |
| <input type="checkbox"/> allergies                  | <input type="checkbox"/> fast metabolism              | <input type="checkbox"/> referred itches           |
| <input type="checkbox"/> cry easily                 | <input type="checkbox"/> headaches/migraines          | <input type="checkbox"/> sneeze in bright sunlight |
| <input type="checkbox"/> depression                 | <input type="checkbox"/> little body hair             | <input type="checkbox"/> tolerates pain poorly     |

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> abdominal pain/constipation | <input type="checkbox"/> difficulty remembering dreams | <input type="checkbox"/> irregular periods           |
| <input type="checkbox"/> all girl family             | <input type="checkbox"/> early greying hair            | <input type="checkbox"/> morning nausea              |
| <input type="checkbox"/> crowded upper front teeth   | <input type="checkbox"/> family history of depression  | <input type="checkbox"/> pale skin                   |
| <input type="checkbox"/> definite breath/body odour  | <input type="checkbox"/> growing pains                 | <input type="checkbox"/> stretch marks               |
| <input type="checkbox"/> depression                  | <input type="checkbox"/> infertility/miscarriage       | <input type="checkbox"/> white marks on finger nails |



# tri-nutrition

## food diary

Please write down a detailed description of ALL your intake, both food and drink, over three convenient days, at least one being a weekend. Specifying: approximate quantity, if the food was home cooked, pre-prepared or from a restaurant and how it was prepared, i.e. fried, roasted, grilled etc. If it was organic, with added salt etc.

	Day 1	Day 2	Day 3
Breakfast			
Mid-morning			
Lunch			
Afternoon			
Dinner			
Other /drinks/snacks			

Many thanks for completing this questionnaire. Please return it in advance of your consultation using the enclosed postage paid envelope.