Cara Wingar
Nutritional Therapist

Nutritional Assessment Questionnaire

Private and Confidential
(The information will not be disclosed to third parties under any circumstances)

Your Personal Details				
Title:	First Name:		Surname:	
Address:				
Tel No-Home:	Work:		Mobile:	
E-mail:				
Date of Birth:	Age:	Height: Weight:	Occupation:	Blood Group:
GP Name & Address:				

Medical History			
Current medically diagnosed health issues (e.g. high blood pressure, cholesterol, hypothyroid, fibromyalgia)	How long have you had this condition?	Please list all prescribed or over the counter medications that you are taking (e.g. the contraceptive pill)	
		Name	Length of time on medication
1.			

2.			
3.			
4.			

Drug Use	
Please **detail past history** of prescribed, illicit or over the counter drugs	
Drug E.g. Antibiotics, paracetamol, cannabis	**Age taken or frequency** Approx 1x year or approx. 3x year age 8-10/ 2x a month for headaches/ age 20-25

Bowel Movements	
Please give details about your bowel movements	
Consistency (e.g. hard, loose, like toothpaste)	Frequency (e.g. once daily, alternate days, 3x a week)

Energy Levels
Please state your energy levels on a scale from one to ten, where 1 is fatigue and 10 is excellent

Health Issues You Wish to Address-Please list all current symptoms in as much detail as possible

Nutritional Therapy may help a wide range of health issues. Please list all the health issues you wish to address in order of priority.		

CHILDHOOD ILLNESSES		
(i.e. Chickenpox, measles, tonsillitis, recurrent urinary tract infections, ear infections, glandular fever, medical operations, accidents requiring hospitalisation etc.)		
Illness	**Medication**	**Age when ill health occurred**

PERSONAL ADULT HEALTH HISTORY

Please list all significant health problems that you have suffered, starting with the most recent and continuing on a separate sheet if necessary			
Health Problem	**Year Started**	**Duration**	**Any medication or supplements (prescribed or otherwise) to manage it**

Family Medical History
Please list below any family health issues that you are aware of:
Brother(s) (age)
Sister(s) (age)
Mother (age)
Father (age)
Maternal Grandmother
Maternal Grandfather
Paternal Grandmother

Paternal Grandfather

Diet	
Do you have any dietary restrictions?	Are you allergic or intolerant to any foods? Please list
Are you vegan, vegetarian or have special needs, religious or cultural requirements for food?	
Have you been tested for any food allergies? If so, when, what type of test and please list any known results	
Are there any goods that you would find it hard to live without?	
Are there any foods that you particularly dislike?	
Do you prepare/cook your own food?	Where do you normally eat meals?
Are you relaxed when you eat?	Do you ever miss meals?

Do you consume any of the following? Please tick the box that best describes the frequency, you can also put a figure for number of times per week/month.			
How many teaspoons of sugar do you add to food or drink each day?		Do you wash fruit and vegetables before eating?	
Do you add salt to your food or during cooking?		Do you normally eat white rice or products made with white flour?	
How many coffees do you drink per day?		How many slices of bread or rolls do you eat per week?	
How many cups of tea per day?		How many pints of cow milk do you drink in a week?	
How often do you eat chocolate or confectionary?		How many times do you eat meat per week (beef, lamb, pork or game)?	
What is your usual alcoholic drink?		How many times do you eat white fish per week?	
…and how many glasses do you drink per week?		How many times do you eat oily fish per week (salmon, herring, sardines, mackerel)?	

…over how many days?		How many times do you eat poultry per week?	
Regularly consume processed foods?		Regularly eat fried foods?	
How many cans of food do you eat in a typical week?		Do you frequently eat under stressed conditions or on the move?	
How many times per week do you have meals containing fried food?		Does your job involve eating out a lot?	
How would you describe your appetite? (good, poor, average, etc)		Drink fizzy drinks?	
		How many servings of vegetables do you have per day?	
How many portions of fruit do you have per day?		Add ketchups, sauces, pickles or vinegar to meals?	
Dilute fruit juices?		Drink bottled or filtered water?	
Drink mainly organic beverages?		Regularly drink herbal teas?	
Regularly eat unsalted nuts and seeds?		Regularly eat beans and lentils?	

Disclaimer:
Information and advice provided by Cara Wingar is not intended as a substitute for medical advice. Anyone suffering from a condition that requires medical attention or who has symptoms that concern them, should consult a qualified medical practitioner. Client information is strictly confidential and will not be released to anyone including your GP unless specific permission by you has been given. You are encouraged to discuss your nutritional programme with your GP.

Deposit
I understand that a non-refundable deposit will be required upon booking an appointment.

Cancellation policy
24 hours cancellation is required for any appointment. I understand that the full fee will be charged if I do not attend my scheduled appointment and have not given sufficient notice as described above.

Declaration
The information provided above is to the best of my knowledge true and accurate. I have read and agree with the above cancellation policy.

Signature: _____ Date: _____