Root Health
NATUROPATHIC NUTRITION

Nutritional Questionnaire

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All information given will be treated with strict confidence. Please answer questions as accurately and with as much detail as possible.

Title:	Name:

Address:	Tel. No.:
	Mobile No.:
	Email:
	Height: Weight:
Date of Birth:	Occupation:
Doctor's name & address:	
	Permission to contact your doctor if necessary? Yes / No

Do you have dependents and/or actively taking care of others? Yes/No (give details if applicable)

Have you any blood, urine, saliva or other laboratory test results? Can you give details?

Are you:
Pregnant? Yes / No
If yes, how many weeks?

Planning to become pregnant or a father? Yes / No
Experiencing fertility problems? Yes / No

Your Main Aims:

Which aspects of your present condition would you most like to improve?

Medical History:

Please list your illnesses/operations, significant or persistent childhood illnesses and any current problems (excluding colds & flu, unless persistent)

Your health history: Illnesses and Operations	Age of onset	Duration	Medication (include current medication/contraceptive pill/HRT)

Are you currently undergoing any form of medical treatment? Yes / No	When did you last take antibiotics?

Are you currently taking any nutritional supplements, herbal or homoeopathic remedies? Please list including dosage and brand name:

Family Health: Are there any illnesses present in your family? E.g. arthritis, heart problems, cancer, diabetes

Your Diet and Eating Habits

Write down all the foods & drinks consumed over the next 2 days, starting today. Please add as much information as possible

Day 1

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Day 2

Breakfast:

Lunch:

Dinner:

Snacks:

Drinks:

Health Check List: Please answer "Y" or circle if relevant; leave blank if symptom does not apply

General Symptoms: Allergies - Frequent Colds/flu- Depression - Fatigue - Fainting spells - Insomnia - Frequent illness -	**Ears:** Itchy ears - Earaches - Ear Infections - Ringing in Ears - Ear Drainage - Hearing Loss -	**Eyes:** Watery Eyes - Itchy or red eyes - Blurred Vision - Tunnel Vision -	
Nose: Stuffy nose - Sinus problems - Hay Fever - Sneezing - Excess Mucus - Nose Bleeds -	**Emotions:** Mood Swings - Anxiety - Nervousness - Anger - Irritability - Depression -	**Heart/Cardiovascular:** Irregular heartbeat - Rapid heartbeat - Chest pains - Swelling of ankles - Poor Circulation - High/Low blood pressure -	
Joint/Muscle: Joint pain - Arthritis - Muscle pain - Varicose veins - Back pain -	**Head:** Dizziness - Headaches – Migraines-	**Lungs/Respiratory:** Chest congestion - Asthma - Shortness of breath - Bronchitis - Chronic Cough -	
Mind: Poor memory - Confusion - Learning – Poor concentration -	**Energy:** Fatigue - Apathy - Hyperactivity - Restlessness -	**Mouth/Throat:** Chronic Sore throat - Swollen gums - Mouth ulcers - Sensitive teeth-nerves – Cold sores-	
Diagnosed Medical Conditions Diabetes- Hepatitis- Cancer- Other (please list)-	**Digestive Tract:** Nausea - Diarrhea - Constipation - Bloating - Belching/burping - Excess Flatulence/Gas - Heartburn/Reflux -	**Urinary Tract** Bladder trouble - Kidney failure - Kidney infection - Kidney stones - Prostate trouble - Chronic UTI's/cystitis - Burning urination -	
Skin: Acne - Boils - Hives or rashes - Hair loss Excessive hair growth- Excess sweating - Dryness - Eczema or psoriasis - Sensitive skin - Bruising easily – Fungal infections-	**Weight:** Binge eating - Cravings - Excessive weight - Compulsive eating - Water retention - Under weight - Eating disorders – Weight fluctuates (more than 5-6lb)	**Women:** Infertility- Fibrocystic breasts - Hysterectomy - Irregular smear tests - Thrush/Yeast infections PMT- Endometriosis – Fibroids- PCOS- PMT- Painful periods- Irregular periods-	**Male** Infertility – Erectile dysfunction- Prostate problems-

Lifestyle:

What is your average alcohol intake? Weekday: Weekend:	Do you smoke? Yes / No If so, how many per day? If you did smoke, when did you give up?
How would you describe your general activity level?	
Do you take regular exercise? Please give details: (activity, duration, how often etc)	
Are there are issues that make you feel stressed at the moment?	
Do you find it hard to relax? Yes / No Do you feel rushed most of the time? Yes / No	Do you have difficulties sleeping? Yes/No
How committed and motivated are you to change the way you eat and experiment with new foods? I am willing to try anything that may benefit my health and improve my condition □ I feel I can cope with a moderate amount of change □ I feel very anxious about changing my diet □	
Any additional comments or useful information:	

Thank you for completing this questionnaire.
Please return to:

ROOT HEALTH Nutrition
Tara Zuluaga Dorgan
11 Riverside Rise
Rushbrooke, Cobh
Cork

prior to your consultation

I appreciate that the nutritional therapist does not diagnose medical conditions, although in some cases may be able to help them. I understand that nutritional therapy is not a substitute for professional medical care

Once you have completed this questionnaire, please sign:

Signature: Date: