The Nutrition Practice

THE NUTRITION PRACTICE – UNDERSTANDING YOUR NEEDS

A. YOUR DETAILS

Name:	Date of Birth (dd/mm/yy)
Occupation:	Nationality:
Company Name (if applicable):	Email:
Address:	
Contact No.:	Fax No.:
Is this your first visit to a nutritional therapist? Yes/No	
BMI:	
Blood Pressure:	

B. LIFESTYLE QUESTIONS

The lifestyle choices that you make, as well as what you eat and drink have a major impact on your health & nutritional needs.

Life & Work	
Do you consider yourself fit?	Yes / No
Do you feel generally that you have less energy than you used to?	Yes / No
Do you find that yourself having mood swings?	Yes / No
Do you have difficulty getting to sleep?	Yes / No
Do you feel that you experience stress on most days, regardless of how you manage stress?	Yes / No
Do you smoke regularly or live in a household with a smoker, or have exposure to second hand smoke?	Yes / No
In your daily routine, do you have regular contact with or exposure to commercial solvents (e.g: dry cleaning solvents, petroleum based products, paint/artist's solvents?)	Yes / No
Do you exercise at least three times a week for at least 15-30 minutes each time? (e.g: walking, jogging or more vigorous activities)	Yes / No
Does your job involve vigorous activity or have physically tiring hobbies?	Yes / No

Diet & Digestion	
Do you typically take more than 1 alcoholic drink per day? (One drink is equal to one beer, wine or cocktail?)	Yes / No
How many servings of rice/noodles/potatoes (carbohydrates) do you eat each day?	__ 0-1 serving __ 2-4 servings __ ≥ 5 servings

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How many servings of fruit and/or vegetables do you eat each day?	__ 0-1 serving __ 2-4 servings __ ≥ 5 servings
On average, how many servings of milk, yogurt, cheese or calcium fortified products do you take each day?	__ none __ 1 serving __ 2 servings __ ≥ 3 servings
Do you consume less than 2 servings of oily fish from cold waters (e.g: salmon, cod, mackerel, sardines) per week?	Yes / No
Do you have tea, coffee, sugary food or drinks at regular intervals during the day?	Yes / No
Do you often feel drowsy during the day?	Yes / No
Do you get dizzy or irritable if you do not eat often?	Yes / No
Are you interested in taking products that might enhance your athletic performance and speed recovery?	Yes / No
Are you prone to stomach upsets/acid reflux?	Yes / No
Do you have regular bowel movement?	Yes / No
Do you regularly consume fast foods or "instant" food?	Yes / No
What, if any foods do you avoid for cultural/ethical or health reasons?	
Do you suspect any foods "don't agree with you"?	
List any food items that you dislike/avoid eating.	
What food items, if any, would you find hard to give up?	

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C. GENDER SPECIFIC CONCERNS

If you are a mum to be – congratulations! Any supplements must be taken only after consult with your doctor/gynaecologist.

Do you experience PMS symptoms regularly, such as mood swings, irritability, bloating, menstrual cramps and/or breast tenderness	**Yes / No**
Do you have brittle nails, dry skin or dry hair?	Yes / No
Do you have irregular menstrual cycles?	Yes / No
Are you experiencing hormonal symptoms including hot flashes, night sweats, mood swings and irritability?	Yes / No
Do you take hormone replacement therapy (estrogen/estrogen-progesterone combinations?)	Yes / No
Do you experience frequent bladder infections/UTI?	Yes / No

Do you suffer from any of the following?

☐ **Asthma**

☐ **Frequent Bloating**

☐ **Hepatitis B Carrier**

What medication, if any, do you take on a regular basis?

Have you had any major surgery, significant periods of ill health in your life, or do you suffer from any chronic or niggling health problems? (please provide brief details)

Do you have any allergies? (please provide brief details)

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D. FAMILY HISTORY

Please select from the following health conditions that apply to any member of your immediate family.

- ☐ Alzheimers Disease
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Stroke
- ☐ Heart Attack
- ☐ Heart Disease (e.g: coronary heart disease)
- ☐ Osteoperosis
- ☐ Others. Please describe.

_____

E. YOUR HEALTH PROFILE

Please select the health goals/concerns that you would like to focus on.

- ☐ Anti-oxidant support
- ☐ Anxiety/Stress
- ☐ Blood Pressure
- ☐ Blood Sugar
- ☐ Bone Health
- ☐ Cholesterol
- ☐ Constipation
- ☐ Difficulty falling or staying asleep
- ☐ Digestion
- ☐ Eye Health
- ☐ Headaches
- ☐ Heart Health
- ☐ Immune Support
- ☐ Inflammation
- ☐ Irritable Bowel Syndrome
- ☐ Joint Health
- ☐ Liver Health
- ☐ Low Energy/Fatigue
- ☐ Memory/Mental Clarity
- ☐ Menopause/PMS
- ☐ Mood Support
- ☐ Respiratory/Lung Health
- ☐ Weight

☐ Others. Please describe.

_____

ACKNOWLEDGMENT AND CONFIRMATION

I declare that the information above is true, complete and accurate and understand that any information or recommendations made by The Nutrition Practice Pte. Ltd. will be based on this information, and the information provided during the consultation. No responsibility can be accepted where incomplete or inaccurate information has been provided.

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It is your responsibility to keep your doctor up to date about the nutritional strategy you have been provided with.

The aim of the nutritional strategy recommended is to facilitate the body's own bio-chemical re-balancing to alleviate distressing symptoms. This advice is not a substitute for professional medical diagnosis, advice and/or treatment.

Fees, to be determined at The Nutrition Practice's discretion, will be charged.

I understand and agree to the above.

_____

Name

Date

_____

Name

The Nutrition Practice Pte. Ltd.

Date: