PRIVATE AND CONFIDENTIAL **Date**:_____

Nutrition & Lifestyle Questionnaire

This questionnaire is designed to provide your nutritionist with all the information necessary to build you an individual nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

First Name: _____ Last Name: _____
Address: _____
_____ Post Code: _____
Telephone Number (Work): _____(Home): _____
Occupation: _____ Age: _____

What is: Your Weight (without clothes):_____ stone _____ lbs OR _____ Kgs.
Your Height (without shoes):_____feet _____inches OR _____ cms

Health Profile

Please make a list of all the health problems you would like to clear up, and indicate how long you have had these problems, eg. Headaches 5 years (continue on the back of this sheet if you need more space)

Health problem	**Duration**
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____

Under what circumstances do these problems improve?_____

Under what circumstances do these get worse? _____

What other illnesses have you had in the past (including childhood)? Approximately when?_____

_____

Do you have any amalgam (silver) dental fillings, crowns or root canals? (Please state)_____

_____

What operations have you had? Approximately when? _____

_____

What medications (drugs) do you take? State daily dosage. _____

_____

What is your normal blood pressure? (If known). _____**Resting pulse rate per minute?**_____
(Take pulse while seated and relaxed. Pulse can be found inside bony protuberance on thumb side of wrist.)

Heredity Profile

Do you have any children? If so, state age and sex._____

How many brothers and sisters do you have? State age and sex._____

Are there any particular illnesses that they suffer from?_____

_____

What illness is/was your father prone to?_____

What illness is/was your mother prone to?_____

Please turn over

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur 2 = Moderate symptom, occurs occasionally (weekly)
1 = **Yes** or Minor or mild symptom (once a month or less) 3 = Severe symptom, frequently occurs (daily)

PART I

Read the following questions and fill in the number that applies:

KEY: **0 (or leave blank) = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2-3 times/month **3 = Consume or use daily**

DIET

1. _____ Alcohol
2. _____ Artificial sweeteners
3. _____ Candy or other sweets
4. _____ Carbonated beverages
5. _____ Chewing tobacco
6. _____ Cigarettes
7. _____ Cigars/pipes
8. _____ Coffee
9. _____ Eat fast food regularly
10. _____ Fried foods
11. _____ Luncheon meats/ hot dogs
12. _____ Margarine
13. _____ Milk products
14. _____ Non-herbal tea
15. _____ Refined flour/ Baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, Tap
20. _____ Water, well
21. _____ Diet often

LIFESTYLE

22. _____ Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week)
23. _____ Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)
24. _____ Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)
25. _____ Work over 60 hours/week (3= always, 2= usually, 1= occasionally, 0= never)

MEDICATIONS

Indicate with a checkmark or circle any medications you're currently taking or have taken in the last month:

26. _____ Antacids
27. _____ Antibiotics
28. _____ Anticonvulsants
29. _____ Antidepressants
30. _____ Antifungals
31. _____ Aspirin/Ibuprofen
32. _____ Asthma inhalers
33. _____ Beta blockers
34. _____ Chemotherapy
35. _____ Cortisone
36. _____ Diabetic medications
37. _____ Diuretics
38. _____ Estrogen/Progesterone
39. _____ Heart medications
40. _____ High blood pressure
41. _____ Hormone Therapy
42. _____ Laxatives
43. _____ Insulin
44. _____ Oral/implant contraceptives
45. _____ Radiation exposure
46. _____ Recreational drugs
47. _____ Relaxants/Sleeping pills
48. _____ Thyroid medication
49. _____ Tylenol/acetaminophen
50. _____ Ulcer medications

Other medications and dosages (if known):

_____

_____

_____

PART II

Read the following questions and fill in the number that applies:

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: **0 (or leave blank) = No or Do not have the symptom, the symptom does not occur**
1 = Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
2 = It is a moderate symptom or it occasionally occurs (weekly)
3 = It is a severe symptom or it frequently occurs (daily)

Section 1 – Upper Gastrointestinal System

51. _____ Belching or gas within 1 hr. of a meal
52. _____ Heartburn or acid reflux
53. _____ Bloating shortly after eating
54. _____ Are you a vegan (no dairy, meat, fish or eggs)
55. _____ Bad breath (halitosis)
56. _____ Loss of taste for meat
57. _____ Sweat has a strong odor
58. _____ Stomach upset by taking vitamins
59. _____ Sense of excess fullness after meals
60. _____ Do you feel like skipping breakfast?
61. _____ Do you feel better if you don't eat?
62. _____ Sleepy after meals
63. _____ Fingernails chip, peel or break easily
64. _____ Anemia unresponsive to iron
65. _____ Stomach pains or cramps
66. _____ Diarrhea, chronic
67. _____ Diarrhea shortly after meals
68. _____ Black or tarry stools
69. _____ Undigested food in stool

Section 2 – Liver and Gallbladder

70. _____ Pain between shoulder blades
71. _____ Stomach upset by greasy foods
72. _____ Greasy or shiny stools
73. _____ Nausea
74. _____ Sea, car or airplane sickness, motion sickness
75. _____ History of morning sickness (1 = yes, 0 = no)
76. _____ Light or clay colored stools
77. _____ Dry skin, itchy feet and/or skin peels on feet
78. _____ Headache over the eye
79. _____ Gallbladder attacks (past or present)
80. _____ Gallbladder removed (1 = yes, 0 = no)
81. _____ Bitter taste in mouth, especially after meals
82. _____ Become sick if drinking wine
83. _____ If drinking alcohol, easily intoxicated
84. _____ Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
85. _____ Recovering alcoholic (1 = yes, 0 = no)
86. _____ Hangovers after drinking alcohol
87. _____ History of drug or alcohol abuse (1 = yes, 0 = no)
88. _____ History of hepatitis (1 = yes, 0 = no)
89. _____ Long term use of prescription medications (1 = yes, 0 =no)
90. _____ Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91. _____ Sensitive to tobacco smoke
92. _____ Exposure to diesel fumes
93. _____ Pain under right side of rib cage
94. _____ Hemorrhoids or varicose veins
95. _____ Nutrasweet (aspartame) consumption
96. _____ Bothered by aspartame (Nutrasweet)
97. _____ Chronic fatigue or Fibromyalgia

Section 3 – Small Intestine

98. _____ Food allergies
99. _____ Abdominal bloating 1 to 2 hours after eating
100. _____ Specific foods make you tired or bloated (1= yes, 0= no)
101. _____ Pulse speeds after eating
102. _____ Airborne allergies
103. _____ Experience hives
104. _____ Sinus congestion, "stuffy head"
105. _____ Crave bread or noodles
106. _____ Alternating constipation and diarrhea
107. _____ Crohn's disease (1 = yes, 0 = no)
108. _____ Wheat or grain sensitivity
109. _____ Dairy sensitivity
110. _____ Are there foods you could not give up (1 = yes, 0 = no)
111. _____ Asthma, sinus infections, stuffy nose
112. _____ Bizarre vivid or nightmarish dreams
113. _____ Use over-the-counter pain medications
114. _____ Feel spacey or unreal

Section 4 – Large Intestine

115. _____ Anus itches
116. _____ Coated tongue
117. _____ Feel worse in moldy or musty place
118. _____ Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
119. _____ Fungus or yeast infections
120. _____ Ring worm, "jock itch", "athletes foot", nail fungus
121. _____ Eating sugar, starch or drinking alcohol increases yeast symptoms
122. _____ Stools hard or difficult to pass
123. _____ History of parasites (1 = yes, 0 = no)
124. _____ Less than one bowel movement per day
125. _____ Stools have corners or edges are flat or ribbon shaped
126. _____ Stools are not well formed (loose)
127. _____ Irritable bowel or mucus colitis
128. _____ Blood in stool
129. _____ Mucus in stool
130. _____ Excessive foul smelling lower bowel gas
131. _____ Bad breath or strong body odors
132. _____ Painful to press along outer sides of thighs (Iliotibial Band)
133. _____ Cramping in lower abdominal region
134. _____ Dark circles under eyes

Section 5 – Mineral Needs

135. _____ History of Carpal Tunnel Syndrome (1 = yes, 0 = no)
136. _____ History of lower right abdominal pain (1 = yes, 0 = no)
137. _____ History of stress fractures
138. _____ Bone loss (reduced density on bone scan)
139. _____ Are you shorter than you used to be? (1 = yes, 0 = no)
140. _____ Calf, foot or toe cramps at rest
141. _____ Cold sores, fever blisters or herpes lesions
142. _____ Frequent fevers
143. _____ Frequent skin rashes and / or hives
144. _____ Have you ever had a herniated disc? (1 = yes, 0 = no)
145. _____ Excessively flexible joints, "double jointed"
146. _____ Joints pop or click
147. _____ Pain or swelling in joints
148. _____ Bursitis or tendonitis
149. _____ History of bone spurs (1 = yes, 0 = no)
150. _____ Morning stiffness
151. _____ Vomiting or nausea
152. _____ Crave chocolate
153. _____ Feet have a strong odor
154. _____ Tendency to anemia
155. _____ Whites of eyes (sclera) blue tinted
156. _____ Hoarseness
157. _____ Difficulty swallowing
158. _____ Lump in throat
159. _____ Dry mouth, eyes and / or nose
160. _____ Gag easily
161. _____ White spots on fingernails
162. _____ Cuts heal slowly and / or scar easily
163. _____ Decreased sense of taste or smell

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Section 6 – Essential Fatty Acids

164. _____ Aspirin is an effective pain reliever (1 = yes, 0 = no)
165. _____ Crave fatty or greasy foods
166. _____ Low or reduced fat diet (past or present)
167. _____ Tension headaches at base of skull
168. _____ Headaches when out in the hot sun
169. _____ Sunburn easily or suffer sun poisoning
170. _____ Muscles easily fatigued
171. _____ Dry flaky skin and or dandruff

Section 7 – Sugar Handling

172. _____ Awaken a few hours after falling asleep, hard to get back to sleep
173. _____ Crave sweets
174. _____ Eat desserts or sugary snacks
175. _____ Binge or uncontrolled eating
176. _____ Excessive appetite
177. _____ Crave coffee or sugar in the afternoon
178. _____ Sleepy in afternoon
179. _____ Fatigue that is relieved by eating
180. _____ Headache if meals are skipped or delayed
181. _____ Irritable before meals
182. _____ Shaky if meals delayed
_____ Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4)
183. _____ Frequent thirst
184. _____ Frequent urination

Section 8 – Vitamin Need

185. _____ Muscles become easily fatigued
186. _____ Feel worse, sore after moderate exercise
187. _____ Vulnerable to insect bites
188. _____ Loss of muscle tone, heaviness in arms / legs
189. _____ Enlarged heart, or heart failure
190. _____ Pulse slow / below 65 (1 = yes, 0 = no)
191. _____ Ringing in the ears / Tinnitus
192. _____ Numbness, tingling or itching in extremities
193. _____ Depressed
194. _____ Fear of impending doom
195. _____ Worrier, apprehensive, anxious
196. _____ Nervous or agitated
197. _____ Feelings of insecurity
199. _____ Heart races
200. _____ Can hear heart beat on pillow at night
201. _____ Whole body or limb jerk as falling asleep
202. _____ Night sweats
203. _____ Restless leg syndrome
204. _____ Cheilosis (cracks at corner of mouth)
205. _____ Fragile skin, easily chaffed, as in shaving
206. _____ Polyps or warts
207. _____ MSG sensitivity
208. _____ Wake up without remembering dreams
209. _____ Take birth control pills
210. _____ Small bumps on back of arms
211. _____ Strong light at night irritates eyes
212. _____ Nose bleeds and / or tend to bruise easily
213. _____ Bleeding gums especially when brushing teeth

Section 9 – Adrenal

214. _____ Tend to be a "night person"
215. _____ Difficulty falling asleep
216. _____ Slow starter in the morning
217. _____ Keyed up, trouble calming down
218. _____ High blood pressure (normal 120/80)
219. _____ Headache after exercising
220. _____ Feeling wired or jittery if drinking coffee
221. _____ Clench or grind teeth
222. _____ Calm on the outside, troubled inside
223. _____ Chronic low back pain, worse with fatigue
224. _____ Become dizzy when standing up suddenly
225. _____ Difficult maintaining manipulative correction
226. _____ Pain after manipulative correction
227. _____ Arthritic tendencies
228. _____ Crave salty foods
229. _____ Salt foods before tasting
230. _____ Perspire easily
231. _____ Chronic fatigue, or get drowsy often
232. _____ Afternoon yawning
233. _____ Afternoon headache
234. _____ Asthma, wheezing or difficulty breathing
235. _____ Pain on the medial or inner side of the knee
236. _____ Tendency to sprain ankles or "shin splints"
237. _____ Tendency to need to wear sunglasses
238. _____ Allergies and / or hives
239. _____ Weakness, dizziness

Section 10 – Pituitary

240. _____ Over 6' 6" tall (Mature height)
241. _____ Early sexual development (before age 10) (1 = yes, 0 = no)
242. _____ Increased libido
243. _____ Splitting type headache
244. _____ Memory failing
245. _____ Ability to tolerate sugar
246. _____ Under 4' 10" (Mature height)
247. _____ Decreased libido
248. _____ Abnormal thirst
249. _____ Weight gain around hips or waist
250. _____ Menstrual disorders
251. _____ Delayed (after age 13) sexual development (1 = yes, 0 = no)
252. _____ Tendency to ulcers or colitis

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Section 11 – Thyroid

253. _____ Allergic to iodine
254. _____ Difficulty gaining weight, even with large appetite
255. _____ Nervous, emotional, can't work under pressure
256. _____ Inward trembling
257. _____ Flush easily
258. _____ Fast pulse at rest
259. _____ Intolerance to high temperatures
260. _____ Difficulty losing weight
261. _____ Mentally sluggish, reduced initiative
262. _____ Easily fatigued, sleepy during the day
263. _____ Sensitive to cold, poor circulation (cold hands and feet)
264. _____ Constipation, chronic
265. _____ Excessive hair loss and / or coarse hair
266. _____ Morning headaches, wear off during the day
267. _____ Loss of lateral 1/3 of eyebrow
268. _____ Seasonal sadness

Section 12 – Men Only

269. _____ Prostate problems
270. _____ Urination difficult or dribbling
271. _____ Difficult to start and stop urine stream
272. _____ Pain or burning with urination
273. _____ Waking to urinate at night
274. _____ Interruption of stream during urination
275. _____ Pain on inside of legs or heels
276. _____ Feeling of incomplete bowel evacuation
277. _____ Decreased sexual function

Section 13 – Women Only

278. _____ Depression during periods
279. _____ Mood swings associated with periods (PMS)
280. _____ Crave chocolate around periods
281. _____ Breast tenderness associated with cycle
282. _____ Excessive menstrual flow
283. _____ Scanty blood flow during periods
284. _____ Occasional skipped periods
285. _____ Variations in menstrual cycles
286. _____ Endometriosis
287. _____ Uterine fibroids
288. _____ Breast fibroids, benign masses
289. _____ Painful intercourse (dyspareunia)
290. _____ Vaginal discharge
291. _____ Vaginal dryness
292. _____ Vaginal itchiness
293. _____ Gain weight around hips, thighs and buttocks
294. _____ Excess facial or body hair
295. _____ Hot flashes
296. _____ Night sweats (in menopausal females)
297. _____ Thinning skin

Section 14 – Cardiovascular

298. _____ Aware of heavy and / or irregular breathing
299. _____ Discomfort at high altitudes
300. _____ "Air hunger" and / or yawn frequently
301. _____ Compelled to open windows in a closed room
302. _____ Shortness of breath with moderate exertion
303. _____ Ankles swell, especially at end of day
304. _____ Cough at night
305. _____ Blush or face turns red for no reason
306. _____ Dull pain or tightness in chest and / or radiate into right arm, worse with exertion
307. _____ Muscle cramps with exertion

Section 15 – Kidney and Bladder

308. _____ Pain in mid back region
309. _____ Dark circles under eyes and / or puffy eyes
310. _____ History of kidney stones (1 = yes, 0 = no)
311. _____ Cloudy, bloody or darkened urine
312. _____ Urine has a strong odor

Section 16 – Immune system

313. _____ Runny or drippy nose
314. _____ Catch colds at the beginning of winter
315. _____ Mucus producing cough
316. _____ Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
317. _____ Frequent colds or flu
318. _____ Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.)
319. _____ Acne (adult)
320. _____ Itchy skin / dermatitis
321. _____ Cysts, boils, rashes
322. _____ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no)

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1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

ENVIRONMENTAL ANALYSIS

Cardiovascular Profile

___Is your blood pressure above 140/90?
___Is your pulse after 15 minutes rest, above 75?
___Are you more than 14lbs (7kg) over your ideal weight?
___Do you smoke? If yes, how many per day?
___Do you do less than two hours exercise a week?
___Do you eat more than one spoon of sugar a day?
___Do you eat meat more than 5 times a week?
___Do you usually add salt to your food?
___Do you have more than 2 alcoholic drinks a day?
___Is there a history of heart disease in your family?

Exercise Profile

___Do you take exercise that noticeably raises your heart beat for 20 minutes more than 3 times a week?
___Does your job involve vigorous activity?
___Do you regularly play a sport? (football, squash, etc.)
___Do you have any physically tiring hobbies? (gardening, etc)
___Do you consider yourself fit?

Pollution Risk Profile

___Do you live in a city or by a busy road?
___Do you spend more than 2 hours a week in traffic?
___Do you exercise (job,cycle, sports) by busy roads?
___Do you smoke more than 5 cigarettes a day?
___Do you live or work in a smoky atmosphere?
___Do you buy foods exposed to exhaust fumes?
___Do you generally eat non-organic produce?
___Do you drink more than 1 unit of alcohol a day? (1 glass of wine, 1 pint of beer, or 1 measure of spirit)
___Do you spend a lot of time in front of a TV or VDU?
___Do you usually drink unfiltered tap water?

Stress Profile

___Is your energy less now than it used to be?
___Do you feel guilty when relaxing?
___Do you have a persistent need for achievement?
___Are you unclear about your goals in life?
___Are you especially competitive?
___Do you work harder than most people?
___Do you easily become angry?
___Do you often do 2 or 3 tasks simultaneously?
___Do you get impatient if people or things hold you up?

Glucose Tolerance Profile

___Do you need more than 8 hours sleep a night?

Digestion Profile

___Do you chew your food thoroughly?
___Are you prone to stomach upsets?
___Do you sometimes suffer from bad breath?
___Do you often get a burning sensation in your stomach?
___Do you find it difficult digesting fatty foods?
___Do you ever use indigestion remedies?
___Do you suffer from flatulence or bloating?
___Do you experience anal irritation?
___How many bowel movements do you have a day?
___Do your stools float?

Immune Profile

___Do you get more than three colds a year?
___Do you find it hard to shift an infection (cold or otherwise)?
___Are you prone to thrush or cystitis?
___Do you take antibiotics more than twice a year?
___Is there a history of cancer in your family?
___Have you ever had any growths or lumps biopsied?
___Do you have an inflammatory disease such as eczema, asthma or arthritis?
___Do you suffer from hayfever?
___Do you suffer from allergy problems?
___Have you had a major personal loss in the last year?

Histamine Profile

Underline the following that apply to you:

-Sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious nature, fat or 'well covered', can tolerate pain.

-Sleep less than 7 hours, strong sex drive, little body hair, family History of allergies, fast metabolism, 'morning person', long toes and fingers, tends towards depression, don't put on weight, poor
tolerance of pain.

Allergy Profile

Do you suffer from any of the following? Please underline.
Nasal problems, hayfever, eczema, dermatitis, asthma, migraine, Irritable bowel syndrome, frequent bloatedness, facial puffiness.
Do you have any allergies?___If so, what?_____
State type of reaction?_____
Have they been tested?_____

What food or drinks would you find hard to give up?_____
_____

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

ADDITIONAL QUESTIONS FOR WOMEN ONLY

___Are you rarely wide awake within 20 minutes of rising?
___Do you need something to get you going in the morning, like a tea, coffee or cigarette?
___Do you have tea, coffee, sugar containing foods or drinks, or cigarettes, at regular intervals during the day?
___Do you often feel drowsy during the day?
___Do you get dizzy or irritable if you don't eat often?
___Do you avoid exercise due to tiredness?
___Do you sweat a lot or get excessively thirsty?
___Do you sometimes lose concentration?
___Is your energy less now than it used to be?

___Are you pregnant? If so, how many weeks?_____
___Are you trying to become pregnant?
___Have you ever had a miscarriage?
___Do you have an IUD fitted, or use the birth control pill? State which_____
___Are your periods regular?
___Are you post-menopausal?
___Do you suffer from any pre-menstrual bloatedness, tiredness,
Irritability, depression, breast tenderness, headaches, stomach
cramps (Please underline)

Diet Analysis

Please tick the questions to which you would answer 'yes' or fill in the 'number of times' you eat the food referred to in the question.

1. ___ Were you breast fed?
2. ___ Was a significant % of your diet as a child high in fatty foods and sugar?
3. ___ Do you eat foods containing preservatives/additives?
4. ___Do you eat foods containing sugar?
5. ___How many teaspoons of sugar do you add to food/drinks per day?
6. ___Do you use salt in your cooking?
7. ___Do you add salt to your food?
8. ___How many coffees do you drink each day?
9. ___How many cups of tea do you drink each day?
10. ___How many times a week do you eat fried foods? (including crisps, chips, samosas, etc.)
11. ___How many ready-made meals or fast foods, do you eat / week?
12. ___How many times a week do you eat chocolate, sweets, cakes and biscuits?
13. ___How many pieces of raw fruit do you eat / day?
14. ___ How many servings of raw vegetables do you eat / day?
15. ___ Do you wash fruit and vegetables before eating?
16. ___ How many cans of food do you eat per week?
17. ___ Do you normally use white rice or white flour?
18. ___ How many slices of bread/rolls do you eat/week?
20. ___ How many pints of milk do you drink per week?
21. ___ How many times a week do you eat red meat? (beef, pork, lamb, duck or game)
22. ___ How many times a week do you eat white meat? (poultry, fish)
23. What are your usual alcoholic drinks?_____
_____
24. ___ How many glasses do you drink a week?_____
25. ___How many times a week do you eat live yoghurt?
26. ___Do you usually drink tap water?
27. ___Do you frequently eat under stressful conditions or on the move?
28. ___Does your job involve eating out a lot?
29. How would you describe your appetite?
a) poor b) average c) good

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2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Write down all the foods and drinks consumed over the next two days, starting today. Please add as much information as possible including quantities eaten, **brand names**, and whether the food is **fresh or packaged**, **refined or natural**.

Day 1	**Day 2**
Breakfast	Breakfast
Lunch	Lunch
Dinner	Dinner
Snacks/Drinks	Snacks/Drinks

Are these two days representative of your usual regularly?

Which Nutritional Supplements do you take

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
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2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Eating habits? If not, what is a more usual day? Please include brand names and quantity. (eg. 500mg)

Breakfast

_____

Lunch

_____

Dinner

_____

Snacks/Drinks

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur 2 = Moderate symptom, occurs occasionally (weekly)
1 = **Yes** or Minor or mild symptom (once a month or less) 3 = Severe symptom, frequently occurs (daily)