

**SCHOOL OF HEALTH AND WELLBEING**

**NUTRITIONAL THERAPY CLINIC CONFIDENTIAL CLIENT QUESTIONNAIRE**

This is a comprehensive health questionnaire and diet diary which will take you some time to complete.

We use client numbers to help ensure confidentiality and the clinic complies with all relevant professional codes.

Once completed please return to [nutritionaltherapyclinic@worc.ac.uk](mailto:nutritionaltherapyclinic@worc.ac.uk)

**Privacy Notice**

We are asking you for this information in order to provide you with the services offered by our student nutritional therapy clinics. this information will enable your student nutritional therapist to provide personalized advice relevant to your needs. If you do not provide us with this information, your student therapist may be unable to tailor their recommendations to your specific circumstances, and may not be able to identify any relevant contraindications.

The information you provide will only be accessed by your student Nutritional Therapists and their assessors as part of any consultations you receive. Any data you provide that is used in written assessments by student Nutritional Therapists will be anonymized.

Our lawful basis for processing your personal data is that it is necessary for a public task (Article 6(1)(e) of the UK GDPR)

Information about your health is special category data. Our condition for processing this data is that it is necessary for the provision of health or social care (article 9(2)(h) of the UK GDPR)

In addition, we have also asked you for information about your ethnicity. This is not required to deliver your clinic, however is required to be collected by our regulatory body (British Association For Nutrition And Lifestyle Medicine – BANT) as part of their equality and ACCESS MONITORING. Our special category condition for processing this information is that it is necessary for REVIEWING THE equality of opportunity or treatment (article 9(2)(g) of the UK GDPR; Schedule 1 Paragraph 8 of the Data Protection Act 2018).

Clinical records will be retained in accordance with the guidelines of the BANT and registrant body, The Complementary and Natural Health Care Council CNHC.

For further details of how the University uses your personal information, please see the [privacy notice](https://informationassurance.wp.worc.ac.uk/data-protection/privacy-notices/research-participants-supporters-and-visitors-privacy-notice/) on our website.

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| --- | --- | --- | --- |
| **DATE** | Click or tap to enter a date. | **CLIENT NUMBER** | Click or tap here to enter client number |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **weight** | **Height** | | | **blood pressure**  **(*If known*)** | | **DOB/Age** | | |
| Click or tap here to enter text. | Click or tap here to enter text. | | | Click or tap here to enter text. | | Click or tap to enter a date. / Click or tap to enter age | | |
| **Gender: M  F** | | | | **Is your gender identity the same as the gender you were given at BIRTH? Yes  no** | | | | |
| **ethnicity**  **(Please add details in the box to the side)** | | | |  | | | | |
| **Married/Single/partner** | |  | **Children** | | **Other dependants** | | | **Smoking** |
| Click or tap here to enter text. | | | Click or tap here to enter text. | | Click or tap here to enter text. | | | **Yes ☐ No ☐** |
| **Previous Occupation/s** | | | Click or tap here to enter text. | | | | | |
| **Occupation**  **(Full or Part time)** | | | Click or tap here to enter text. | | | | Click here to enter full or part time. | |
| **PLEASE DESCRIBE BRIEFLY THE CONDITION(S) WHICH YOU WOULD LIKE SOME HELP WITH: INCLUDE ANY RECENT GP TEST RESULTS IF YOU HAVE THEM** | | | | | | | | |
| Click or tap here to enter text. | | | | | | | | |

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| **HEALTH HISTORY**  Please list any ***serious*** illnesses, health conditions, accidents or operations you have had, plus courses of antibiotics, if any (*please include childhood*) | | |
| illness, health condition, accident or operation | MEDICAL TREATMENT RECEIVED | APPPROXIMATE DATE OR ONGOING |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| This the Nutritional Therapy “Red Flag” symptom list, which, if you have any of these symptoms, may indicate that you need to consult your GP or other health care practitioner if you have not already done so. If you tick that you have any of the symptoms below, we will discuss in the consultation. | | | | | | | |
| DO YOU HAVE ANY PERSISTENT PAIN IN ANY OF THE FOLLOWING (*Please tick any which apply to you)* | | | | | | | |
| Head |  | Abdomen |  | Chest |  | Eye |  |
| Temple |  | On passing urine |  | Other (*please state*) Click or tap here to enter text. | | |  |
| **DO YOU EVER GET BLOOD IN ANY OF THE FOLLOWING: (***Please tick any which apply to you*) | | | | | | | |
| Vomit |  | Stools |  | Urine |  | Sputum |  |
| **HAVE YOU RECENTLY NOTICED ANY CHANGES IN: (***Please tick any which apply to you*) | | | | | | | |
| Level of Thirst |  | Weight |  | Appetite |  | Skin |  |
| Vision |  | Digestion or Bowel Movements |  | Urination |  | Waist Size |  |
| Body / Face Shape |  | Swallowing |  | Breathing |  | Personality / Mood |  |

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| **PLEASE LIST ALL PRESCRIBED MEDICATIONS YOU CURRENTLY TAKE. IF IT IS EASIER ATTACH YOUR PRESCRIPTION (***include pills, injections, patches or other devices*) | | |
| **name of medication** | **dose** | **length of time taken and reason** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| **PLEASE LIST ANY OVER THE COUNTER MEDICATIONS and NUTRITIONAL SUPPLEMENTS THAT YOU REGULARLY TAKE**  (*Including. antacids, pain relief pills, anti-histamines, anti-inflammatory drugs, herbal & nutritional supplements*). | | |
| **name of over the counter medication/supplement** | **dose** | **length of time taken and reason** |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
| Click or tap here to enter text. | Click or tap here to enter text. | Click or tap here to enter text. |
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| **HEALTH SCREEN - FAMILY HISTORY**  *Please indicate if any of the following conditions have occurred in your family - (M = Male; Fe =Female)* | | | | | | | | | | |
| **Condition** | **Grandparents** | | | | **Parents** | | **Siblings** | | **Children** | |
| **Paternal** | | **Maternal** | |
| **M** | **Fe** | **M** | **Fe** | **M** | **Fe** | **M** | **Fe** | **M** | **Fe** |
| Alcoholism |  |  |  |  |  |  |  |  |  |  |
| Allergies |  |  |  |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  |  |  |  |
| Asthma / Eczema / Hay fever |  |  |  |  |  |  |  |  |  |  |
| Autoimmune Condition |  |  |  |  |  |  |  |  |  |  |
| Cancer |  |  |  |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  |  |  |  |
| Alzheimer’s/Dementia |  |  |  |  |  |  |  |  |  |  |
| Diabetes |  |  |  |  |  |  |  |  |  |  |
| Heart Disease / Stroke / High Blood Pressure |  |  |  |  |  |  |  |  |  |  |
| IBS |  |  |  |  |  |  |  |  |  |  |
| Crohn’s, Colitis, Coeliac |  |  |  |  |  |  |  |  |  |  |
| Obesity |  |  |  |  |  |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |  |  |  |  |  |

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| **ANY FURTHER NOTES ON FAMILY MEDICAL HISTORY** |
| Click or tap here to enter text. |

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| **DO YOU DO ANY TYPE OF EXERCISE? yes**   **no**  **FOR EXAMPLE ANY GYM CLASSES, RUNNING GROUP ETC. PLEASE PROVIDE DETAILS BELOW IN REGARD TO WHAT SORT OF EXERCISE AND HOW OFTEN A WEEK YOU DO IT & FOR HOW LONG.** | | |
| Click or tap here to enter text. | | |
| **DO YOU DO ENGAGE IN ANY PHYSICAL ACTIVITY yes**   **no**  **THIS CAN BE HOUSEWORK, YOUR WORK COMMUTE IF WALKING OR CYCLING, CARING RESPONSIBILITIES WHERE YOU ARE ACTIVE. PLEASE PROVIDE DETAILS BELOW.**  **SRESPONSIBILITIES** | | |
| Click or tap here to enter text. | | |
| **WHAT DO YOU DO TO RELAX?** | | |
| Click or tap here to enter text. | | |
| **TYPICAL STRESS LEVELS** *(tick the appropriate box below)* | | |
| **Low** | **High** | |
| 1  2  3  4  5  6  7  8  9  10 | | |
| **EATING PATTERN** *(where do you eat, and approximately what times of the day)* | | |
| Click or tap here to enter text. | | |
| **SHOPPING** *(where, how, who….)* | | |
| Click or tap here to enter text. | | |
| **APPROXIMATELY HOW MUCH DO YOU SPEND A WEEK ON FOOD?** | | Click or tap here to enter text. |
| **ARE YOU PREPARED TO SPEND ANYMORE AND IF SO, HOW MUCH?** | | Click or tap here to enter text. |
| **COOKING** *(who…..)* | | |
| Click or tap here to enter text. | | |
| **DESCRIBE YOUR APPETITE** | | |
| Click or tap here to enter text. | | |
| **HOW IS YOUR SLEEP?** | | |
| Click or tap here to enter text. | | |
| **HOW IS YOUR WEIGHT MANAGEMENT?** | | |
| Click or tap here to enter text. | | |
| **please mention anything else you think might be relevant** | | |
| Click or tap here to enter text. | | |

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| **SYMPTOM SCAN** | | | | | |
| **The details given here will help your therapist to work on your case so please give as much detail as you can; the boxes will expand as you type into them and *leave blank* anything not applicable.** | | | | | |
|  | Severity of symptoms on a scale of 1-10 where 1 is mild and 10 is as bad as it can be | Approximate date you first noticed the symptoms | | Additional comments | |
| **HEAD** | | | | | |
| Headaches/Migraines | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Fuzzy head | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Dizzy | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Poor balance | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Easily intoxicated by alcohol | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| HAIR |  |  | |  | |
| Oily | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Dry | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Thin /thinning | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| MOUTH |  |  | |  | |
| Sore tongue | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Sore throat | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Ulcers | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Bad breath | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Poor taste | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Bleeding gums | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Fillings | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Root canals | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| EYES |  |  | |  | |
| Gritty | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Burning | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Sticky/itchy | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Dry | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Blurred vision | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| EARS | | | | | |
| Blocked | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Itchy | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Ringing/Tinnitus | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| NOSE | | | | | |
| Blocked nose | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Post nasal drip | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Persistent sneezing | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Nose bleeds | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **ENERGY** | | | | | |
| Tired all or some of the time | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Need more than 8 hours sleep | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Hard to get up | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Too tired to exercise | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Irritable/mood swings if miss a meal | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Energy slumps | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **MOOD** | | | | | |
| Poor memory/concentration | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| General low mood | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Occasional low mood | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Anxiety | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Impatient /intolerant | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **SKIN** | | | | | |
| Eczema | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Psoriasis | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Acne | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Dry | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Oily | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Puffy | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **IMMUNE** | | | | | |
| Coughs/colds | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Sinus | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Asthma | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Allergies: If yes please state below what you are allergic to. | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **IMMUNE Continued** | | | | | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| **HEART/LUNGS** | | | | | |
| High Blood Pressure | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Low Blood Pressure | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Poor circulation | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Palpitations | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Arrhythmias | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Short of breath | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Cough | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| JOINTS AND MUSCLES | | | | | |
| Please describe any joint or muscle issues you have below | | | | | |
|  | Select required number | | Enter apx. date | | Click or tap here to enter text. |
| **DIGESTION** | | | | | |
| Bloating | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Wind | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Cramping | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Constipation | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Diarrhoea | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Ulcers/Gastritis | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Heartburn | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Indigestion | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Nausea | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Pain | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Diagnosed IBS | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Diagnosed IBD | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Hiatus Hernia | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| Other | Select required number | Enter apx. date | | Click or tap here to enter text. | |
| FEMALE ONLY QUESTIONS | | | | | |
| What age did your periods start? | Click or tap here to enter text. | | | | |
| Are you periods regular | Click or tap here to enter text. | | | | |
| How many days is/was your normal cycle? | Click or tap here to enter text. | | | | |
| How is/was the flow? | Click or tap here to enter text. | | | | |
| Duration of bleeding | Click or tap here to enter text. | | | | |
| Mood before and during your period | Click or tap here to enter text. | | | | |
| Breast tenderness | Click or tap here to enter text. | | | | |
| Endometriosis | Click or tap here to enter text. | | | | |
| Uterine fibroids | Click or tap here to enter text. | | | | |
| Excessive facial/body hair? | Click or tap here to enter text. | | | | |
| Low libido | Click or tap here to enter text. | | | | |
| Have you had fertility problems or fertility treatment? Please give details | Click or tap here to enter text. | | | | |
| Have you ever had a miscarriage? | Click or tap here to enter text. | | | | |
| Have you had pregnancy complications? Please give details | Click or tap here to enter text. | | | | |
| If menopausal, date of last period | Click or tap here to enter text. | | | | |
| Symptoms of menopause please describe | Click or tap here to enter text. | | | | |
| Other | Click or tap here to enter text. | | | | |
| MALE ONLY QUESITONS | | | | | |
| Prostate problems | Click or tap here to enter text. | | | | |
| Pain on urination | Click or tap here to enter text. | | | | |
| Frequent urination | Click or tap here to enter text. | | | | |
| Erectile dysfunction | Click or tap here to enter text. | | | | |
| Fertility issues | Click or tap here to enter text. | | | | |
| Low libido | Click or tap here to enter text. | | | | |
| Other | Click or tap here to enter text. | | | | |

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| **PLEASE ADD ANYTHING ELSE NOT COVERED BY THE ABOVE QUESTIONS** | | |
| Click or tap here to enter text. | | |
| **NUTRITION and DIET** | | |
| ***Please tick those boxes that relate to your present diet*** | | |
| Mixed food/flexitarian diet (*animal and vegetable sources*) | |  |
| Pescatarian (vegetables, grains, pulses fish and other seafood) | |  |
| Vegan (*No animal products*) | |  |
| Lacto vegetarian (*No meat, fish, poultry or eggs but eats dairy*) | |  |
| Lacto ovo vegetarian (*No meat, fish or poultry but eats dairy and eggs*) | |  |
| Low salt | |  |
| Low fat | |  |
| Low carbohydrate | |  |
| Counting calories | |  |
| Other; please describe | |  |
| **Please list any foods you exclude from you diet and why** | | |
| Click or tap here to enter text. | | |
| Have you taken any food allergy/intolerance tests? Please state type of test undertaken and results | | |
| Click or tap here to enter text. | | |
| How motivated are you to change the way you eat and to experiment with new foods? | | |
| I am willing to try anything that might improve my wellbeing |  | |
| I feel I can make some changes |  | |
| I don’t really want to change anything |  | |

**FOOD DIARY**

|  |  |  |  |
| --- | --- | --- | --- |
| Please choose 2 fairly typical weekdays and a weekend (or day-off) and record. Please give as much information as possible: home cooked or not, brand names, fresh, packaged, whole, refined, organic, skimmed etc. and approximate quantities to help your Nutritional Therapist build an accurate picture of your diet and lifestyle. | | | |
| **DAY 1** | | | |
| **time** | **all food(s) eaten (*include snacks*) and drinks**  ***e.g. Water, Coffee, Tea, Herbal tea, Juice, Fizzy, Alcohol etc*** | **approx. quantity** | **other information**  *e.g. Brands, Sugar or Salt Added* |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
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| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| **DAY 2** | | | |
| **time** | **all food(s) eaten (*include snacks*) and drinks**  ***e.g. Water, Coffee, Tea, Herbal tea, Juice, Fizzy, Alcohol etc*** | **approx. quantity** | **other information**  *e.g. Brands, Sugar or Salt Added* |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
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| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |

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| **DAY 3** | | | |
| **time** | **all food(s) eaten (*include snacks*) and drinks**  ***e.g. Water, Coffee, Tea, Herbal tea Juice, Fizzy, Alcohol etc.*** | **approx. quantity** | **other information**  *e.g. Brands, Sugar or Salt Added* |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
| 00:00 | Click or tap here to enter text. | Approx. Qty. | Click or tap here to enter text. |
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| ***IF YOU ARE UNDER 18 YOU WILL NEED CONSENT FROM A PARENT OR GUARDIAN TO SEE A NUTRITIONAL THERAPIST*** |
| **Name of Parent / Guardian:** Click or tap here to enter text.  **Parent / Guardian Signature:** Click or tap here to enter text.  **date** Click or tap to enter a date. |

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| **Please return questionnaire within one week (at least a week prior to the consultation) to:** |
| **Nutritional Therapy Clinic**  School of Health & Wellbeing  Department of Community, Social Juctice and Health  ECB G008, Elizabeth Casson,  Severn Campus,  Hylton Road,  Worceser, WR2 5JN  [nutritionaltherapyclinic**@worc.ac.uk**](mailto:nutritionaltherapyclinic@worc.ac.uk) |