

**Welcome to Absolute Nutrition.**

**ABOUT YOUR APPOINTMENT**

Before your appointment you will be asked to complete as best as you can the Nutrition Programme Questionnaire. Don't worry if you cannot answer all the questions, or find some ambiguous. You will have time to go through these with your nutrition consultant.

If this is your first consultation you will spend about an hour discussing your particular health problems or reason for coming, resulting in a recommended diet and supplement programme for you to follow. If you wish a colleague to sit in with you that is fine. If you are under 16 it is a legal requirement that a guardian or parent be present. Anything you say or any information you give during a consultation is completely confidential. You will then be provided with a report regarding your meeting. Fees for initial appointments are £70 adults, £60 children under 16. Please make cheques payable to Absolute Nutrition.

**TESTS**

You may be recommended to have some tests to find out more precisely what is going on. If you wish to have recommended blood or urine tests, kits will be sent to you or you visit the Clinics based in Central London. You will pay your nutritionist the test fee. The results of many tests are available within 24 – 48 hours. However, some tests take ten days to be returned. Please call your nutrition consultant should you have a query about a test. You will always be given a copy of your test results.

**FOLLOW-UP**

There is no set procedure for follow up consultations. The fee for follow up consultations is less than for initial consultations as these take up to half an hour. Fees are £45 Adults, £40 children under 16. Some nutrition consultations can be followed up by telephone appointments on the same basis to minimise your travel. Fees for telephone appointments are the same as personal consultations and must be paid in advance.

**CANCELLATIONS AND MISSED APPOINTMENTS**

If you need to cancel an appointment please give 48 hours notice. If you do not, or if you miss your appointment you will incur a full charge cancellation fee. The reason for this is that appointments for other clients cannot be booked at such short notice and clinic rent has to be paid whether or not the client turns up.

**SUPPLEMENTS**

Your nutrition consultant may recommend you to take a course of dietary supplements. Should you have any problems or questions concerning your supplement programme please call your nutrition consultant. It is also recommended you check with your nutrition consultant before altering your supplement programme.

Your nutritionist will recommend a supplement programme that will be available from the Nutri Centre, an organisation that serves nutritionists and their clients.

**DISCLAIMER**

Your nutritionist cannot accept any responsibility whatsoever for theft or damage to your property while on the premises so please be sure you keep your belongings with you.

**Nutrition Programme Questionnaire**

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

First Name  Last name  Client Number

Address

Post Code

Telephone Home  Work  Mobile

Email  Occupation

Age  DOB  May I contact your medical doctor if necessary? Yes  No

Medical Doctor's Address

Post Code  Telephone

Your Weight  stone  lbs  kgs

Your Height  feet  inches  cms

**Health Profile**

Please make a list of all the health problems you would like help with, and indicate how long you have had these problems e.g. Headaches 5 years (continue on a separate sheet if you need more space).

	Health Problem	Duration
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	<input type="text"/>

Have you seen a health professional regarding your current symptoms? Yes  No

If so, what type of health professional have you seen?

Have you had any blood, urine, saliva or any other laboratory tests? Yes  No

If yes, please state which tests below and if possible, bring a copy of the results to the consultation.

**Personal Health History**

Please list all significant health problems you have encountered during your life. Indicate, where appropriate, the duration, timing and management of the health problem. Please continue on a separate sheet as necessary.

Health Problem	Duration	Management	Date or Age of Onset
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Family Medical History**

Please complete as much family history to enable a greater understanding of your health problems in a wider context of your genetic inheritance.

Father                      Mother                      Brother/Sister                      Grandparents                      Children

# ABSOLUTE NUTRITION

Any illnesses

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Allergies

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Disease

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## Lifestyle Analysis

Please answer the questions as accurately as possible; some questions may not apply to you so ignore those that you do feel appropriate.

### Digestion Profile

Do you have a good appetite? Yes  No

Do you have a poor sense of taste or smell? E.g. Do you add salt or do you like your food spicy?

Are you prone to stomach upsets? Yes  No

Do you suffer from indigestion or a burning sensation in your stomach? Yes  No

Do you need to use indigestion tablets? Yes  No

If yes, which medication do you use?

Do you find it difficult digesting fatty foods? Yes  No

Do you suffer from nausea or vomiting? Yes  No

Do you suffer from flatulence or bloating? Yes  No

Do you have irritable bowel syndrome? Yes  No

How often do you have a bowel movement?

Do you suffer from constipation? Yes  No

Do you suffer from diarrhoea? Yes  No

Do your stools float? Yes  No

Are your stools offensive in smell? Yes  No

Do you have anal irritation? Yes  No

### Immune Profile

How often do you get colds or sore throats?

How long does it take to shift an infection?

How many courses of antibiotics have you had?

When was the last course of antibiotics?

Are you allergic to anything, if so what?

Have you suffered from thrush or cystitis and when?

Do you suffer from any inflammatory diseases such as eczema, asthma or arthritis? Yes  No

If yes, which ones and duration

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## Absolute Nutrition

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## ABSOLUTE NUTRITION

Do you suffer from hayfever or rhinitis?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have dark circles under your eyes?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from migraine?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from mouth ulcers?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from athlete's foot or fungal nail infections or vitiligo?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you ever had Glandular fever, hepatitis or ME?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have slow wound healing?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

### Endocrine Profile

What are your energy levels like?	<input type="text"/>			
Do you suffer from anxiety or stress?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you suffer from depression?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have concentration problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have memory problems?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you need more than 8 hours sleep a night?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you need something to get you going in the morning?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If yes, what?	<input type="text"/>			
Do you crave sugary foods?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get irritable or dizzy if you don't eat?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you feel drowsy during the day, and at what time?	<input type="text"/>			
Do you sweat a lot?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have cold hands and feet?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you get excessively thirsty?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you sleep well?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
If no, why?	<input type="text"/>			

### Additional Questions for men only to target any hormonal related problems

Do you suffer from altered urine flow?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Have you been diagnosed with benign prostatic hyperplasia or hypertrophy?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you impotent?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Are you infertile?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Do you have low sperm count/motility?	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>

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### Additional Questions for Women only to target any hormonal related problems.

Are you pregnant? Yes  No

If so how many weeks?

Are you trying to become pregnant? Yes  No

Are you having or had infertility treatment? Yes  No

Have you ever had a miscarriage? Yes  No

Do you have an IUD fitted, or use birth control pills? Please state:

Are your periods regular? Yes  No

Have you ever had an abnormal smear result? Yes  No

Have you had a hysterectomy? Yes  No

Are you post menopausal? Yes  No

Do you, or have you taken HRT? Yes  No

If yes, when and how long?

Do you suffer from any of the following premenstrual symptoms? Please tick all that apply.

bloating  tiredness  irritability  depression  breast tenderness  mood swings

headaches  oedema  cravings for what

### Cardiovascular Profile

Is your blood pressure above 140/90? Yes  No

Are you more than 14lbs (7kg) over your ideal weight? Yes  No

Do you smoke more than 5 cigarettes a day? Yes  No

Do you eat more than one spoon of sugar a day? Yes  No

Do you eat meat more than 5 times a week? Yes  No

Do you add salt to your food? Yes  No

Do you have more than 2 alcoholic drinks a day? Yes  No

Is there a history of heart disease in your family? Yes  No

Do you have pale skin? Yes  No

How often do you exercise?

Do you suffer from water retention or oedema? Yes  No

Do you have palpitations or irregular heart beat? Yes  No

### Musculoskeletal Profile

Do you suffer from muscle cramps or spasms? Yes  No

Do you suffer from tender or sore muscles? Yes  No

Do you have joint pain or arthritis? Yes  No

If yes, which joints?

Do you have dry flaky skin? Yes  No

Do you have red pimples on your skin especially on your arms? Yes  No

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## ABSOLUTE NUTRITION

Please record accurate quantities where possible so that the analysis may be more thorough and circle times when foods consumed.

Day 1	Foods	Quantity	Snacks & drinks
6 am – 10 am			
10 am – 2 pm			
2 pm – 6 pm			
6 pm – 12 am			
Day 2	Foods	Quantity	Snacks & drinks
6 am – 10 am			
10 am – 2 pm			
2 pm – 6 pm			
6 pm – 12 am			
Day 3	Foods	Quantity	Snacks & drinks
6 am – 10 am			
10 am – 2 pm			
2 pm – 6 pm			
6 pm – 12 am			

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