

Absolute Nutrition

PLEASE READ THIS BEFORE YOUR CONSULTATION

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.

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.

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.

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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 Mobile

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"/>

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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
Any illnesses	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Allergies	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Disease	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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 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 or asthma? Yes No

If yes, which ones and duration

Do you suffer from hayfever or rhinitis? Yes No

Do you have dark circles under your eyes? Yes No

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- Do you suffer from migraine? Yes No
- Do you suffer from mouth ulcers? Yes No
- Do you suffer from athlete's foot or fungal nail infections or vitiligo? Yes No
- Have you ever had Glandular fever, hepatitis or ME? Yes No
- Do you have slow wound healing? Yes No

Endocrine Profile

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

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 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
- 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

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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? 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

For infants:

Personality as an infant:- (please tick as appropriate)

Content

Wide awake

Restless

Discontented

Spoiled

Impulsive

Lazy

Unhappy

Temper tantrums

Aggressive

Nervous

Excitable

Irritable

Terror

Cries often

Very good

Very neat

Clumsy

Demanding

Head banging

Sleepy

Tough

Rocking

All over the place

Placid

Was the child breast-fed? Yes No

If yes, until what age?

If bottle fed please state what age this began?

Which formula milk was given?

At what age did weaning start?

Which foods were introduced first? (please put in order)

a)

b)

c)

d)

e)

f)

g)

h)

Did any foods upset the child when they were introduced? Yes No

If Yes, please state which and the reaction they caused.

Has the child been immunised? Yes No

If Yes, please state immunisation history, giving dates if possible:-

1)

2)

3)

4)

5)

6)

Please ensure you fill out both sides of the dietary analysis sheet including the 3-day diary sheet as accurately as possible.

First Name

Last name

Client
Number

Diet Analysis

Do you eat organic?

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Do you drink filtered or bottled water?	
How many teaspoons of sugar do you add to your food/drinks each day?	
Do you use salt in cooking and on food?	
How many coffees do you drink each day?	
How many cups of tea do you drink each day?	
How many times a week do you eat chocolate?	
What percentage of your diet is raw fruit and raw vegetables?	
What percentage of your diet is fatty food or fried food?	
How many times a week do you eat red meat?	
How many times a week do you eat white meat?	
How many times a week do you eat fish?	
How many pints of milk do you drink a week?	
How many slices of bread or rolls do you eat each week?	
Do you eat refined or unrefined food?	
What is your usual alcoholic drink?	
What foods do you crave?	
What foods would you find hard to give up?	
Are you on a special diet at the moment?	
Do you, or have you experienced an eating disorder?	
Do you enjoy food?	

Please list all nutritional supplements currently taken and any medication, continue on a separate sheet if necessary.

Brand	Nutrient/Drug	Dosage	How Taken	Long

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 and
6 am – 10am			
10am – 2pm			
2 pm – 6pm			

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6 pm – 12am			
Day 2	Foods	Quantity	Snacks and
6 am – 10am			
10am – 2 pm			
2 pm – 6 pm			
6 pm – 12am			
Day 3	Foods	Quantity	Snacks and
6 am – 10am			
10am – 2 pm			
2 pm – 6 pm			
6 pm – 12am			