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Health & Dietary Questionnaire

For BRIS Wellbeing use only

Private and Confidential

Please provide details as fully and accurately as possible. If at any time you need more space, please continue on a separate sheet.

General

Please list your main health concerns in order of priority including how long you have experienced the problem and any medication you have taken to treat it.

Health concern	Duration	Medication
(1)		
(2)		
(3)		
(4)		

Antibiotic history

Please state when and why you last took antibiotics plus any previous times you can remember.

Is there any other medication that you have taken over a length of time or have had to take repeatedly? Please include over the counter medication.

Name of medication	Year started	Reason for taking	Duration & dosage

Vitamins and Supplements

Please list any nutritional supplements and/or herbal supplements you are currently taking or have done in the past.

Supplement (product name & manufacturer)	Dose	Reason for taking	Duration	Current or past?

Please list any major operations/accidents you have had (if any)

Year	Details

Have you had any recent health tests? Please specify or attach as appropriate.

Year	Details

Lifestyle habits

	Yes	No
Do you smoke?		
Have you ever smoked?		
If you replied yes to either please specify how many and for how long you have smoked.		
Do you use recreational drugs?		
Have you ever used recreational drugs?		
If you replied yes to either please specify type of drug, frequency and for how long you took them.		
Do you currently exercise regularly?		
What type of exercise do you practice?		
How many times a week?		
For how long do you exercise each time?		

Women only

	yes	no
Are you breastfeeding?		
Have your periods ever stopped for any reason other than pregnancy?		
Do you have regular periods?		
Have you ever had any miscarriages? If yes, please state how many and when:		
Have you started the menopause? If yes, please state when:		
How many children have you given birth to? Please provide the ages:		

Family history

Please list any illnesses or conditions that your family members have experienced.

Mother		Maternal Grandmother	
		Maternal Grandfather	
Father		Paternal Grandmother	
		Paternal Grandfather	
Sister(s)		Brother(s)	
Children			

Dietary history

Approximately how many times a day *or* a week do you consume the following foods? Please use one of the frequency columns depending on how often you consume each food.

FOOD	Number of times a day	Number of times a week	FOOD	Number of times a day	Number of times a week
Red meat (Beef, lamb etc)			Grains (wheat) (breakfast cereal, pasta, bread etc)		
White meat (Chicken, turkey etc)			Other grains (rye, rice, oats, millet, corn etc.)		
White fish (Cod, plaice, haddock etc)			Nuts (almonds, Brazil nuts, cashew nuts, peanuts etc.)		
Oily Fish (Sardines, tuna, salmon etc)			Seeds (sunflower, pumpkin, sesame etc)		
Vegetarian alternatives (soy burgers, tofu, quorn etc)			Cakes/biscuits		
Pulses and beans (lentils, kidney beans etc)			Sweets/chocolate		
Eggs			Desserts		
Dairy Products (milk, cheese, yogurt, butter)			Ready meals		
Dairy alternatives (soy milk, soy yoghurt, oat, almond milks etc)			Take-aways		
Fruit (fresh, dried, tinned)			Restaurant food		
Vegetables (salads, cooked etc)			Home cooked food		

Other foods

Please list other foods and snacks frequently consumed and state frequency

FOOD	Number of times a day	Number of times a week	FOOD	Number of times a day	Number of times a week

Drinks

Approximately how many times a day *or* a week do you drink the following beverages? Please use one of the frequency columns depending on how often you drink each beverage.

BEVERAGES	**How many teaspoons of sugar do you add to each drink?**	**Number of cups/glasses a day**	**Number of cups/glasses a week**
Tea			
Coffee			
Coffee (decaffeinated)			
Fruit juice			
Squash			
Carbonated soft drinks			
Herbal teas			
Water			
Other (please state)			

Alcohol

Please indicate how many units per day you consume and the type of alcohol that you drink.

Type of drink	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
One small glass (125 ml) of wine at 9% is one unit							
25ml pub measure of spirit at 40% is one unit							
Half a pint of beer/lager/cider at 3.5% is one unit							

Dietary Restrictions and Intolerances

Please describe any food intolerances and/or allergies that you may have?
Do you have any dietary restrictions for religious reasons? If yes, please specify.
Which are your favourite foods?
Which foods do you dislike or make you unwell?
Are there any foods that you would find it difficult to live without? Please list.
How often do you follow fad diets? If yes, please specify which types, how many times in the past 10 years and for how long.
Do you consume 'low fat foods'? If yes, please give examples.

Please tick cooking methods generally used:

Boil		steam	
grill		deep-fry	
shallow-fry		bake	
roast		microwave	

What type of fat do you usually use in cooking? Please list all used.

Do you eat any of the following **organic** foods regularly? Please circle which.
meat fish root vegetables only all vegetables salad fruit eggs dairy

	yes	no
Do you use artificial sweeteners? If yes, please state which.		
Do you add salt to your food or when cooking?		
Do you add stock cubes or other types of flavour enhancers to your cooking?		
Do you eat processed meat, such as: salami, pepperoni, sausages, beef burgers, ham?		
Do you use condiments or sauces? If yes, please state which.		

	Yes	No
Are you vegan?		
Are you vegetarian?		
Do you eat fish?		
Do you eat at regular times each day?		
Do you usually eat when stressed?		
Do you read food labels?		

Has your diet always been the same? If not, please detail.
How long do you usually have for eating?
How does your diet differ between weekdays and weekends?

Please use the scale below to rate how stressed you have felt over the past month: Low stress 1 2 3 4 5 6 7 8 9 10 High stress
How motivated are you to change your diet and lifestyle? Low motivation 1 2 3 4 5 6 7 8 9 10 High motivation

Please sign below to confirm that the medical and other information given in this form is accurate to the best of your knowledge.

Client Signature: _____ **Date**:_____

Thank you for completing this questionnaire. Please save it to your computer and return a copy to your practitioner at least 3 days prior to your appointment.