

Jacqui Mayes

nutritional therapy

HEALTH CHECK

All details on this questionnaire will be held private and confidential.

Please answer all questions as appropriate

PERSONAL DETAILS

Date:

Please state: Mr Mrs Miss Master Dr Other

Surname: **First name:** **Marital Status:**

Date of birth: **Height:** **Weight:**

Occupation:

No. of dependents: **Age/sex of children:**

Contact address:

..... **Post code:**

Contact tel no: **Emergency contact no:**

Medical doctor's address:

..... **Post code:** **Doctor's tel no:**

Do you give permission for your medical doctor to be contacted? tick for yes

Is your medical doctor aware of your intention to see a dietary therapist?

Have you seen a dietary therapist or any other health professional before regarding your current symptoms?

Do you give permission for a student or other professional to witness your consultation?

How did you hear about the clinic service?

Please state your main reason/s for seeking dietary support

Please bring copies of any test results that you have had done previously.

	tick for yes	Comments
Are you currently following a medically prescribed diet?	<input type="checkbox"/>
Are you currently undergoing medical treatment?	<input type="checkbox"/>
Are you pregnant, or aiming to become pregnant?	<input type="checkbox"/>
Do you have a medically identified food allergy or intolerance?	<input type="checkbox"/>

MEDICATIONS and SUPPLEMENTS. Please use a separate sheet if necessary.

Please list below any prescribed drugs – current or in the past

Medication	Dose	Condition being treated	Frequency	Duration	current	past
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

Please list below any Over the Counter Medicines – current or in the past

Medication	Dose	Condition being treated	Frequency	Duration	current	past
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

Please list below any vitamins, minerals, herbs and other Supplements – current or in the past

Supplement	Dose	Condition being treated	Frequency	Duration	current	past
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>
.....	<input type="checkbox"/>	<input type="checkbox"/>

HEALTH ZONE CHECKS

zone 1

Thorough completion of zone 1 enables your therapist to understand your health problems in the wider context of your family history.

Is there any history of health problems or disease in your family?

	tick for yes	Comments
Grandfathers	<input type="checkbox"/>
Grandmothers	<input type="checkbox"/>
Father	<input type="checkbox"/>
Mother	<input type="checkbox"/>
Brothers	<input type="checkbox"/>
Sisters	<input type="checkbox"/>
Sons	<input type="checkbox"/>
Daughters	<input type="checkbox"/>

zone 2

Thorough completion of zone 2 provides your therapist with a comprehensive picture of your health history enabling a wholistic approach to your health.

Personal Health History

Starting with the most current health problems please list in the space provided, all significant health problems that you have encountered in your lifetime. Indicate, where appropriate, the duration, timing and management of the health problem. *Please continue on a separate sheet as necessary.*

Example:

Health Problem	Duration	Management	Date
migraines	20 years	Migrileve	1976-current
abdominal pain	2 years	Paracetamol appendicectomy	1966-1968 1968
asthma	25 years	Ventolin wheat free diet	1971-1998 Jan 2000
.....
.....
.....
.....
.....
.....
.....
.....
.....

zone 3

Zone 3 helps your therapist to identify some key symptoms that might need medical referral. This is not a definitive list. *Please tick if yes to the following questions.*

any unexplained pain	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	numbness	<input type="checkbox"/>
bleeding from nipple	<input type="checkbox"/>	constipation	<input type="checkbox"/>	paralysis	<input type="checkbox"/>
bleeding from vagina	<input type="checkbox"/>	depression	<input type="checkbox"/>	persistent cough	<input type="checkbox"/>
blood in sputum	<input type="checkbox"/>	diarrhoea	<input type="checkbox"/>	persistent nose bleeds	<input type="checkbox"/>
blood in stool	<input type="checkbox"/>	difficulty swallowing	<input type="checkbox"/>	shortness of breath	<input type="checkbox"/>
blood in urine	<input type="checkbox"/>	discharge from vagina	<input type="checkbox"/>	slurred speech	<input type="checkbox"/>
blood in vomit	<input type="checkbox"/>	excessive thirst	<input type="checkbox"/>	unexplained bruising	<input type="checkbox"/>
blurred vision or dizziness	<input type="checkbox"/>	frequent urination	<input type="checkbox"/>	unexplained heavy periods	<input type="checkbox"/>
breast lumps	<input type="checkbox"/>	headaches	<input type="checkbox"/>	unexplained loss of periods	<input type="checkbox"/>
calf swelling	<input type="checkbox"/>	inability to gain weight	<input type="checkbox"/>	unexplained rash	<input type="checkbox"/>
change in nature of moles	<input type="checkbox"/>	loss of appetite	<input type="checkbox"/>	unexplained weight loss	<input type="checkbox"/>

zone 4

The following questions help your therapist to identify specific areas of imbalance in the body. Please tick if yes to the following questions.

Weight

- fluctuating weight
- fast metabolism
- inability to gain weight
- inability to lose weight
- sudden weight loss
- unexplained weight loss
- unhappy with weight
- water retention
- weight gain:
 - back and shoulders
 - central
 - hips and thighs

Sleep

- asleep after midnight
- difficulty waking up
- disordered sleeping pattern
- feel sleepy during the day
- feel tired all the time
- feel un-refreshed after sleep
- get up after 9am
- insomniac
- need less than 7 hours sleep
- need more than 8 hours sleep
- shift worker
- wake up during the night

Mood

- aggression/anger
- anxiety/tension
- apathetic
- competitive
- depression
- easily provoked
- easily satisfied
- frustration
- hyperactive
- irritability
- mood swings
- passive

Energy

- best evenings
- best mornings
- difficulty getting to sleep
- difficulty getting up
- exhaustion
- fatigue
- feel tired all the time
- fluctuating energy
- hyperactivity
- lethargic
- low energy

Digestion + Assimilation

- bloating
- bolt food
- can't tolerate fatty meals
- eat on the move
- eat when stressed
- flatulence
- heartburn
- indigestion
- pain under right rib-cage
- pain under right shoulder-blade
- reflux

Elimination

- anal irritation
- blood/black stool
- constipation
- infrequent bowel action
- offensive stool
- pale, bulky stool
- stools that float
- stools that sink
- diarrhoea
- haemorrhoids
- mucus or pus in stool

Inflammation

- acne
- arthritis
- asthma
- boils
- bronchitis
- cancer
- cardiovascular disease
- conjunctivitis
- Crohn's Disease
- cystitis
- dermatitis
- diverticulitis

- eczema
- food allergy/intolerance
- gastritis
- gingivitis
- hayfever
- hepatitis
- hives
- IBS
- infections
- joint pains
- labyrinthitis
- mastitis

- nephritis
- oesophagitis
- otitis media
- pancreatitis
- pelvic inflammatory disease
- prostatitis
- psoriasis
- rhinitis
- sinusitis
- SLE
- ulcers
- urethritis

Toxic Load and Detoxification

- additives and preservatives
- anal itching
- arthritis/joint pains
- caffeine keeps you awake
- cellulite
- chronic allergies
- chronic headaches
- coated tongue
- colds/infections
- constipation
- dark circles under the eyes
- dark coloured urine
- dehydration
- drug use including recreational
- dull headaches
- exercise by busy main roads
- feeling of a hangover
- feel worse in damp weather
- high electrical exposure

- high exposure domestic moulds
- high intake of oily fish
- high intake of red meat
- hormone problems
- inflammatory disorder
- irritability
- lethargy
- little fruit or vegetables
- live in a polluted environment
- low fibre intake
- low nutrient dense diet
- mercury fillings
- muscle aches
- nail infection
- offensive body odour
- offensive breath
- offensive stools
- offensive urine
- pesticide exposure

- play golf regularly
- processed foods
- regular alcohol
- scanty urine
- sensitivity to chemicals
- signs of premature ageing
- smoke cigarettes
- thrush/athletes foot
- tinnitus
- travell's diarrhoea
- unexplained itching/rashes
- use garden chemicals
- verruca/warts
- unwashed fruit and vegetables
- water retention
- weight loss
- work in a polluted environment
- worms or parasites
- yellow discolouration, skin/eyes

zone 7

These questions are for men only and help your therapist specifically target any hormonal related problems. *Please tick if yes to the following questions.*

- | | | | | | | | |
|------------------------------|--------------------------|----------------------------|--------------------------|---------------------|--------------------------|----------------------|--------------------------|
| acne | <input type="checkbox"/> | diminished sweating | <input type="checkbox"/> | impotence | <input type="checkbox"/> | poor concentration | <input type="checkbox"/> |
| altered urine flow | <input type="checkbox"/> | dry skin, face & hands | <input type="checkbox"/> | infertility | <input type="checkbox"/> | poor memory | <input type="checkbox"/> |
| benign prostatic hyperplasia | <input type="checkbox"/> | excessive sweating | <input type="checkbox"/> | infrequent shaving | <input type="checkbox"/> | prostatitis | <input type="checkbox"/> |
| benign prostatic hypertrophy | <input type="checkbox"/> | feel cold | <input type="checkbox"/> | loss of hair | <input type="checkbox"/> | prostate cancer | <input type="checkbox"/> |
| coarse hair | <input type="checkbox"/> | headaches | <input type="checkbox"/> | loss of hair colour | <input type="checkbox"/> | protruding eyes | <input type="checkbox"/> |
| cold extremities | <input type="checkbox"/> | high exposure to chemicals | <input type="checkbox"/> | low energy | <input type="checkbox"/> | swollen neck/goitre | <input type="checkbox"/> |
| depression | <input type="checkbox"/> | hyperactive | <input type="checkbox"/> | low sperm count | <input type="checkbox"/> | testicular cancer | <input type="checkbox"/> |
| | <input type="checkbox"/> | hypospadias | <input type="checkbox"/> | low sperm motility | <input type="checkbox"/> | undescended testicle | <input type="checkbox"/> |
| | <input type="checkbox"/> | | <input type="checkbox"/> | mentally dull | <input type="checkbox"/> | | <input type="checkbox"/> |

zone 8

The following questions help your therapist to identify the likelihood of adrenal and blood glucose imbalance. *Please tick if yes to the following questions.*

- | | | | | | | | |
|----------------------------|--------------------------|---------------------------------|--------------------------|-------------------------|--------------------------|---------------------------------|--------------------------|
| addicted to any foods | <input type="checkbox"/> | excessive thirst | <input type="checkbox"/> | impotence | <input type="checkbox"/> | panic attacks | <input type="checkbox"/> |
| addicted to any stimulants | <input type="checkbox"/> | excessive urination | <input type="checkbox"/> | inflammatory disorder | <input type="checkbox"/> | poor concentration | <input type="checkbox"/> |
| anxiety/tension | <input type="checkbox"/> | feel cold | <input type="checkbox"/> | irritability | <input type="checkbox"/> | poor co-ordination | <input type="checkbox"/> |
| blurred vision | <input type="checkbox"/> | feel faint without regular food | <input type="checkbox"/> | lack of sex drive | <input type="checkbox"/> | poor memory | <input type="checkbox"/> |
| clammy skin | <input type="checkbox"/> | fluctuating energy | <input type="checkbox"/> | low blood pressure | <input type="checkbox"/> | sleep more than 8 hours | <input type="checkbox"/> |
| clumsy | <input type="checkbox"/> | food allergies | <input type="checkbox"/> | low protein diet | <input type="checkbox"/> | sudden weight loss | <input type="checkbox"/> |
| depression | <input type="checkbox"/> | food cravings | <input type="checkbox"/> | mainly refined foods | <input type="checkbox"/> | sugary foods | <input type="checkbox"/> |
| diabetes | <input type="checkbox"/> | food intolerances | <input type="checkbox"/> | mood swings | <input type="checkbox"/> | tired, particularly after lunch | <input type="checkbox"/> |
| difficulty getting up | <input type="checkbox"/> | headaches/migraines | <input type="checkbox"/> | nausea without food | <input type="checkbox"/> | weight gain | <input type="checkbox"/> |
| difficulty sleeping | <input type="checkbox"/> | high carbohydrate diet | <input type="checkbox"/> | need for frequent meals | <input type="checkbox"/> | | <input type="checkbox"/> |
| digestive disturbance | <input type="checkbox"/> | hyperactivity | <input type="checkbox"/> | osteoporosis | <input type="checkbox"/> | | <input type="checkbox"/> |
| dizziness | <input type="checkbox"/> | | <input type="checkbox"/> | palpitations | <input type="checkbox"/> | | <input type="checkbox"/> |

zone 9

The following questions help your therapist identify stressors in your life. *Please tick if yes to the following questions.*

- | | | | | | | | |
|--------------------------------|--------------------------|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|--------------------------|
| addicted to stimulants | <input type="checkbox"/> | exposure to chemicals | <input type="checkbox"/> | legal problems | <input type="checkbox"/> | redundancy/retirement | <input type="checkbox"/> |
| changed jobs | <input type="checkbox"/> | exposure to pollutants | <input type="checkbox"/> | multi task | <input type="checkbox"/> | regular drug use | <input type="checkbox"/> |
| competitive | <input type="checkbox"/> | feel too hot or too cold | <input type="checkbox"/> | new parent | <input type="checkbox"/> | relax easily | <input type="checkbox"/> |
| dazzled by lights | <input type="checkbox"/> | financial loss | <input type="checkbox"/> | personal achievement | <input type="checkbox"/> | shift worker | <input type="checkbox"/> |
| dizzy from sitting to standing | <input type="checkbox"/> | food allergies | <input type="checkbox"/> | physical illness | <input type="checkbox"/> | unclear about your goals | <input type="checkbox"/> |
| easily angered | <input type="checkbox"/> | food intolerance | <input type="checkbox"/> | physical injury | <input type="checkbox"/> | unhappy at home | <input type="checkbox"/> |
| easily irritated | <input type="checkbox"/> | hormone imbalance | <input type="checkbox"/> | recently bereaved | <input type="checkbox"/> | unhappy at work | <input type="checkbox"/> |
| easily satisfied | <input type="checkbox"/> | inflammatory disorder | <input type="checkbox"/> | recently married | <input type="checkbox"/> | | <input type="checkbox"/> |
| excessive exercise | <input type="checkbox"/> | insomnia | <input type="checkbox"/> | recently moved house | <input type="checkbox"/> | | <input type="checkbox"/> |
| | <input type="checkbox"/> | job promotion | <input type="checkbox"/> | recently separated | <input type="checkbox"/> | | <input type="checkbox"/> |

zone 10

The following questions help your therapist target the health of your circulation. *Please tick if yes to the following questions.*

- | | | | | | | | |
|-----------------------|--------------------------|------------------------|--------------------------|-----------------------------|--------------------------|---------------------|--------------------------|
| abdominal weight gain | <input type="checkbox"/> | diabetes | <input type="checkbox"/> | high fat diet | <input type="checkbox"/> | red face | <input type="checkbox"/> |
| anaemia | <input type="checkbox"/> | excessive exercise | <input type="checkbox"/> | high triglycerides | <input type="checkbox"/> | shortness of breath | <input type="checkbox"/> |
| angina | <input type="checkbox"/> | feel cold | <input type="checkbox"/> | lung disease | <input type="checkbox"/> | smoker in the past | <input type="checkbox"/> |
| arteriosclerosis | <input type="checkbox"/> | feel faint on standing | <input type="checkbox"/> | minimal exercise | <input type="checkbox"/> | smoker now | <input type="checkbox"/> |
| atherosclerosis | <input type="checkbox"/> | feel hot | <input type="checkbox"/> | nose bleeds | <input type="checkbox"/> | sugary foods | <input type="checkbox"/> |
| blood clotting | <input type="checkbox"/> | feel stressed | <input type="checkbox"/> | obesity | <input type="checkbox"/> | thread veins | <input type="checkbox"/> |
| blue extremities | <input type="checkbox"/> | frustrated | <input type="checkbox"/> | over-committed | <input type="checkbox"/> | varicose veins | <input type="checkbox"/> |
| calf pain | <input type="checkbox"/> | groin pain | <input type="checkbox"/> | pain in legs on walking | <input type="checkbox"/> | water retention | <input type="checkbox"/> |
| chest pain | <input type="checkbox"/> | headaches | <input type="checkbox"/> | peripheral vascular disease | <input type="checkbox"/> | weight gain | <input type="checkbox"/> |
| club fingers | <input type="checkbox"/> | high blood pressure | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> |
| crease in ear | <input type="checkbox"/> | high cholesterol | <input type="checkbox"/> | | <input type="checkbox"/> | | <input type="checkbox"/> |

zone 11

Zone 11 helps your therapist identify more about your individual body type. *Please tick if yes to the following questions.*

- | | | | | | |
|-------------------------------|--------------------------|------------------------------|--------------------------|-------------------------------|--------------------------|
| allergies | <input type="checkbox"/> | addictive/obsessive nature | <input type="checkbox"/> | abdominal pain/constipation | <input type="checkbox"/> |
| anaemia | <input type="checkbox"/> | all boy family | <input type="checkbox"/> | all girl family | <input type="checkbox"/> |
| blood clotting disorders | <input type="checkbox"/> | allergies | <input type="checkbox"/> | crowded upper front teeth | <input type="checkbox"/> |
| cancer | <input type="checkbox"/> | cry easily | <input type="checkbox"/> | definite breath/body odour | <input type="checkbox"/> |
| chronic fatigue | <input type="checkbox"/> | depression | <input type="checkbox"/> | depression | <input type="checkbox"/> |
| early onset diabetes | <input type="checkbox"/> | excess salivation | <input type="checkbox"/> | difficulty remembering dreams | <input type="checkbox"/> |
| heart disease | <input type="checkbox"/> | family history of depression | <input type="checkbox"/> | early greying hair | <input type="checkbox"/> |
| inflammatory conditions | <input type="checkbox"/> | fast metabolism | <input type="checkbox"/> | family history of depression | <input type="checkbox"/> |
| intolerant to dietary changes | <input type="checkbox"/> | headaches/migraines | <input type="checkbox"/> | growing pains | <input type="checkbox"/> |
| lupus | <input type="checkbox"/> | little body hair | <input type="checkbox"/> | infertility/miscarriage | <input type="checkbox"/> |
| multiple sclerosis | <input type="checkbox"/> | light sleeper | <input type="checkbox"/> | irregular periods | <input type="checkbox"/> |
| reactive immune system | <input type="checkbox"/> | long fingers and toes | <input type="checkbox"/> | morning nausea | <input type="checkbox"/> |
| sensitive digestive tract | <input type="checkbox"/> | referred itches | <input type="checkbox"/> | pale skin | <input type="checkbox"/> |
| ulcers | <input type="checkbox"/> | sneeze in bright sunlight | <input type="checkbox"/> | stretch marks | <input type="checkbox"/> |
| vulnerable immune system | <input type="checkbox"/> | tolerates pain poorly | <input type="checkbox"/> | white marks on finger nails | <input type="checkbox"/> |
| broad chest | <input type="checkbox"/> | creative | <input type="checkbox"/> | dreams a lot | <input type="checkbox"/> |
| churly hair | <input type="checkbox"/> | defined moons on fingernails | <input type="checkbox"/> | easily aroused | <input type="checkbox"/> |
| dry warm skin | <input type="checkbox"/> | domed forehead | <input type="checkbox"/> | easily fatigued | <input type="checkbox"/> |
| energetic | <input type="checkbox"/> | flat-feet | <input type="checkbox"/> | expressive eyes | <input type="checkbox"/> |
| good sleeper | <input type="checkbox"/> | intuitive | <input type="checkbox"/> | fine/silky hair | <input type="checkbox"/> |
| gregarious nature | <input type="checkbox"/> | knock-knees | <input type="checkbox"/> | fine/shapely hands | <input type="checkbox"/> |
| heavy jaw | <input type="checkbox"/> | large head | <input type="checkbox"/> | little body hair | <input type="checkbox"/> |
| large teeth | <input type="checkbox"/> | large teeth | <input type="checkbox"/> | heightened sexuality | <input type="checkbox"/> |
| little dental decay | <input type="checkbox"/> | lax joints | <input type="checkbox"/> | long chest/long neck | <input type="checkbox"/> |
| low hair-line | <input type="checkbox"/> | long limbs | <input type="checkbox"/> | often dissatisfied | <input type="checkbox"/> |
| physically stocky | <input type="checkbox"/> | stimulant dependency | <input type="checkbox"/> | poor concentration | <input type="checkbox"/> |
| powerful muscle tone | <input type="checkbox"/> | strong sex drive | <input type="checkbox"/> | small, narrowly spaced teeth | <input type="checkbox"/> |
| short neck | <input type="checkbox"/> | tall | <input type="checkbox"/> | thin body | <input type="checkbox"/> |
| thick or short fingers/toes | <input type="checkbox"/> | tolerates pain well | <input type="checkbox"/> | wake early and refreshed | <input type="checkbox"/> |

zone 12

Zone 12 helps your therapist identify the level of body imbalance that you are currently experiencing or have experienced in the past. *Please tick if yes to the following questions.*

--

- | | | | | | | | |
|------------------------|--------------------------|------------------------|--------------------------|-----------------------|--------------------------|---------------------|--------------------------|
| accidents | <input type="checkbox"/> | cirrhosis of the liver | <input type="checkbox"/> | gall-bladder disease | <input type="checkbox"/> | multiple sclerosis | <input type="checkbox"/> |
| alzheimer's disease | <input type="checkbox"/> | Coeliac disease | <input type="checkbox"/> | hernia | <input type="checkbox"/> | physical handicap | <input type="checkbox"/> |
| arthritis | <input type="checkbox"/> | Chron's disease | <input type="checkbox"/> | kidney disease | <input type="checkbox"/> | thyroid overactive | <input type="checkbox"/> |
| bronchiectasis | <input type="checkbox"/> | diabetes | <input type="checkbox"/> | manic depression | <input type="checkbox"/> | thyroid underactive | <input type="checkbox"/> |
| cancer | <input type="checkbox"/> | diverticular disease | <input type="checkbox"/> | M.E. | <input type="checkbox"/> | schizophrenia | <input type="checkbox"/> |
| cardiovascular disease | <input type="checkbox"/> | emphysema | <input type="checkbox"/> | mental handicap | <input type="checkbox"/> | SLE | <input type="checkbox"/> |
| chronic fatigue | <input type="checkbox"/> | epilepsy | <input type="checkbox"/> | motor neurone disease | <input type="checkbox"/> | Ulcer | <input type="checkbox"/> |

Please indicate any other diagnosed health problem you have or have had in the past?

.....

zone 13

Please answer the following questions relating your level of physical activity.

- | | |
|-------------------|--|
| Are you: | Explain the type of exercise, frequency , duration and place of regular exercise. |
| active | <input type="checkbox"/> |
| moderately active | <input type="checkbox"/> |
| sedentary | <input type="checkbox"/> |

- Do you enjoy exercise? If you do not participate in regular exercise, please indicate the factors that prevent you from doing so
-
-

zone 14

Zone 14 helps your therapist understand your attitudes to diet and your social circumstances in regard to food. *Elaborate or tick for yes.*

Are there any foods that you crave?

Are there any foods that you dislike?

What are your favourite foods?

Which foods would you find hard to give up?

Are you following a special diet, now or in the past?

Do you

or have you experienced an eating disorder?

cater for a special diet in the family?

eat lots of wheat and dairy products?

eat out frequently?

eat when stressed?

not avoid additives and preservatives?

Is your diet repetitive?

Do you

cook for more than one?

enjoy eating and preparing food?

enjoy entertaining?

have a good appetite?

mainly purchase organic produce?

Have you recently changed your diet?

Is shopping easy for you?

zone 15

Completing zone 15 helps your therapist identify the frequency of intake of specific foods and pollutants. *Please indicate the number of exposures as applicable.*

How many biscuits in a week?	How many eggs a week?
How many cakes/pastries in a week?	How many glasses of water a day?
How many cups of coffee a day?	How many raw salads in a week?
How many cups of tea a day?	How many slices of bread a day?
How many cigarettes a week?	How many tomatoes a week?
How many pints of milk a week?	How much cheese a week?
How many units of alcohol a week?	How many portion of (a portion = 80 grams)
How much chocolate in a week?	broccoli a week?
Quantity of red meat* in a week?	cabbage a week?
Quantity of white fish in a week?	carrots a week?
Quantity of oily fish in a week?	fruit a day?
Quantity of Poultry in a week?	red berries a week?
	vegetables a day?

*red meat = beef, pork, lamb and processed foods like ham, burgers and sausages

zone 16

Completing zone 16 gives your therapist a deeper insight into your current dietary choices. *Please tick if yes to the following questions.*

Do you

add salt to cooking or food?

add sugar to food or drink?

drink tea or coffee?

drink decaffeinated tea or coffee?

frequently add prepared pickles and vinegar to meals?

frequently add prepared sauces and ketchups to meals?

mainly cook with vegetable oils?

mainly drink tap water?

mainly eat white bread?

mainly use margarines?

mainly use unrefined oils?

regularly chew gum, toffees or sweets?

regularly eat fried food?

regularly eat processed food?

regularly eat ready prepared meals?

regularly eat salted and roasted nuts?

regularly eat smoked and barbecued food?

regularly eat take-away meals?

regularly microwave food?

Do you

avoid additives and preservatives?

choose mainly low-fat food?

dilute fruit juices?

drink mainly bottled water?

drink mainly filtered water?

drink mainly organic beverages?

eat mainly fresh fruit and vegetables?

eat mainly organic produce?

eat mainly wholegrain bread, pasta & cereals?

regularly drink herbal teas?

regularly eat beans and lentils?

regularly eat seeds?

use olive oil/butter for cooking?

wash/peel chemically treated fruit and vegetables?

Were you

breast-fed?

raised on a healthy diet?

zone 17

Completing zone 17 helps your therapist understand how you put your meals together.

Typical Weekday

Breakfast Time

.....

.....

Lunch Time

.....

.....

Dinner Time

.....

.....

Snacks Times of

.....

.....

Drinks

.....

.....

Typical Saturday

Breakfast Time

.....

.....

Lunch Time

.....

.....

Dinner Time

.....

.....

Snacks Times of

.....

.....

Drinks

.....

.....

Typical Sunday

Breakfast Time

.....

.....

Lunch Time

.....

.....

Dinner Time

.....

.....

Snacks Times of

.....

.....

Drinks

.....

.....

If you have recently changed your diet describe a prior typical day

Breakfast Time:

.....

.....

Lunch Time:

.....

.....

Dinner Time

.....

.....

Snacks Times of

.....

.....

Drinks

.....

.....

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Jacqui Mayes BSc (Hons) mBANT
Chestnut Cottage, Bentley, Farnham, Surrey, GU10 5HZ
nutrition@jacquimayes.co.uk 07710 098 280 www.jacquimayes.co.uk