**QUESTIONNAIRE**

 Email:

Name and address

Date of Birth Male/female

Occupation: Marital Status

Children: Y/N How many?

Any long-term Illness, If yes please specify

Medications, If yes please list

Surgical procedures, If yes please specify

Please rate your physical activity: 1- 2- 3- 4- 5 -6 -7
(1 = none and 7= daily (30mins or more)

What types?

Weight: kg or St/lbs Height: cm/ft

Have you received dietary advice before? Y / N If yes who was it with?

Do you have a goal or aim for the future that you are hoping to achieve?

Who shops? How often?

Who cooks? Alcohol/wk?

How often do you eat take-aways /week? What type? List the take-away you use:

Fill in the following table record the number of times in a week you eat these and list by product name i.e.: 125g spelga yoghurt, 2 tablespoons of helmans.

|  |  |  |
| --- | --- | --- |
| Chocolate: | Pudding/ice-cream: | Fruit |
| Crisps/nuts: | Chips: | Vegetables |
| Sweets: | Jam: | Sauce/mayo |
| Biscuits: | Diet food: | Pulses/ quorn/ soya |
| Bread type: | Sugar/sweeteners | Yogurts/cheese |
| Dairy Spread | Fizzy drinks | Leftovers |

Any Food or drink dislikes:

Please use this box to fill in any further information you feel may be relevant to assist the consultation, ie: Sleep patterns, alcohol intake, shift work, smoker, depression, family issues. Weight history, either increase or decrease, bowel concerns, acid reflux, nausea, vomiting.

I consent to you contacting my GP

GP Details:

Thank you for your details they will be treated in the strictest confidence.