

Eating For Beauty  
35 Barkers Road  
Sheffield S7 1SD  
0114 2551345



**Eating For Beauty Questionnaire (Private and Confidential)**

This questionnaire is designed to provide your Applied Nutrition Therapist with all the information necessary to build you an individual programme specially tailored to your needs.

First name..... Last name.....  
Address.....  
.....  
Age..... Occupation.....  
Telephone (Home)..... (Work/Mobile).....

**Major Beauty Concerns**

Please indicate the issue you would most like to address initially.....  
.....

**Please Answer Yes/No to the following questions (where applicable)**

**SKIN**

- 1. Is your skin in good condition?.....
- 2. Is your skin Greasy?.....
- 3. Is your skin Dry?.....
- 4. Do you suffer from Spots?..... If yes please circle where: Face Torso Limbs
- 5. Do you suffer from Eczema?..... If yes please circle where: Face Torso Limbs
- 6. Are you concerned about wrinkles?.....
- 7. Do you have Cellulite?.....

**NAILS**

- 1. Are your nails brittle?.....
- 2. Do your nails break easily?.....
- 3. Do you bite your nails?.....
- 4. Do your nails split?.....
- 5. Are your nails ridged?.....

**HAIR**

- 1. Is your hair Glossy?.....
- 2. Is your hair Greasy?.....
- 3. Do you colour your hair?.....
- 4. Is your hair Dry?.....
- 5. Do you have Split Ends?.....

**WEIGHT**

- 1. Your weight ..... stone .....lbs
- 2. Your height ..... feet .....inches.
- 3. Are happy with your current weight?.....
- 4. Are you currently dieting.....
- 5. Are you a frequent dieter?.....  
If yes please lists diets you have used.....

**Helpful Information**

Please indicate any illnesses you have had in the past ten years.....  
.....

Please indicate any operations you have had.....  
.....

What medications (drugs) do you take?.....  
.....  
.....  
.....

## Nutritional Assessment

Each question in this section are symptoms associated with nutritional deficiency. Please underline/circle each of the conditions if they have occurred in the last year. Some symptoms are repeated. Please underline/circle them in all cases.

Mouth ulcers  
 Poor night vision  
 Acne  
 Frequent colds or infections  
 Flaky dry skin  
 Dandruff  
 Thrush or cystitis  
 Diarrhoea  
 Dry skin  
 Rheumatism or arthritis  
 Backache  
 Tooth decay  
 Hair loss  
 Muscle cramp, tremors or spasms  
 Joint pain or stiffness  
 Lack of energy

Lack of sex drive  
 Exhaustion after light exercise  
 Easy bruising  
 Slow wound healing  
 Varicose veins  
 Loss of muscle tone  
 Infertility

Frequent colds  
 Bleeding or tender gums  
 Lack of energy  
 Frequent infections  
 Easy bruising  
 Nose bleeds  
 Slow wound healing  
 Red pimples on skin

Poor concentration  
 Irritability  
 Depression  
 Anxiety or tension  
 Poor skin condition  
 Lack of energy  
 Headaches

Blood shot, burning or gritty eyes  
 Sensitive to bright lights  
 Sore tongue  
 Cataracts  
 Dull or oily hair  
 Eczema or dermatitis  
 Split nails  
 Cracked lips

Infrequent dream recall  
 Water retention  
 Tingling hands  
 Depression or nervousness  
 Irritability  
 Muscle tremors, cramps or spasms  
 Lack of energy

Dry skin  
 Poor hair condition.  
 Premature greying hair  
 Tender or sore muscles  
 Poor appetite or nausea  
 Frequent sunburn  
 Constipation

Muscle cramps or tremors  
 Insomnia or nervousness  
 Joint pain or arthritis  
 Tooth decay  
 High Blood pressure  
 Irregular heart beat  
 Fits or convulsions

Hyperactivity  
 Addicted to sweet foods

PMS or breast pain  
 Eczema or dry skin  
 Dry eyes  
 High blood pressure  
 Inflammatory health problems  
 Drink alcohol every day  
 Excessive thirst  
 Mental health problems

Dry skin  
 Water retention  
 Prone to infection  
 Declined memory or learning ability  
 Lack of coordination or blurred vision  
 High blood pressure or raised triglycerides

### Number of amalgam fillings

*(i.e. silver fillings)*

.....

### Blood Group

*(please circle if known)*

O A B AB

### Do you use nutritional supplements? ...Yes No.

If yes please list with as much detail as possible, including frequency of use.

.....  
 .....  
 .....  
 .....  
 .....

# LIFESTYLE ANALYSIS

## Exercise Profile

- ..... Do you take exercise that noticeably raises your heart beat for 20 mins more than three times a week?
- ..... Does your job involve vigorous activity?
- ..... Do you regularly play sport, football, squash, etc.)
- ..... Do you have any physically tiring hobbies? (gardening, etc.)
- ..... Do you consider yourself fit?

## Pollution Risk Profile

- ..... Do you live in a city or by a busy road?
- ..... Do you spend more than 2 hrs a week in traffic?
- ..... Do you exercise (job cycle, play sports) by busy roads?
- ..... Do you smoke more than 5 cigarettes a day?
- ..... Do you work or live in a smoky atmosphere?
- ..... Do you buy foods exposed to exhaust fumes?
- ..... Do you generally eat non organic produce?
- ..... Do you drink more than 1 unit/oz of alcohol per day? (1 glass of wine, 1 pint of beer or 1 measure of spirits.)
- ..... Do you spend a lot of time in front of a TV or VDU?
- ..... Do you usually drink unfiltered tap water?

## Stress profile

- ..... Is your energy less now than it used to be?
- ..... Do you feel guilty when relaxing?
- ..... Do you have a persistent need for achievement?
- ..... Are you unclear about your goals in life?
- ..... Are you especially competitive?
- ..... Do you work harder than most people
- ..... Do you easily become angry?
- ..... Do you often do 2 or 3 tasks simultaneously?
- ..... Do you get impatient if people or things hold you up?
- ..... Do you have difficulty getting to sleep?

## Blood Sugar Profile

- ..... Do you need more than 8 hrs sleep a night?
- ..... Are you rarely wide awake within 20 mins of rising?
- ..... Do you need something to get you going in the morning.  
Like a tea coffee or cigarette?
- ..... Do you have tea, coffee, sugar containing foods or drinks, or cigarettes, at regular intervals during the day?
- ..... Do you often feel drowsy during the day?
- ..... Do you get dizzy or irritable if you don't eat often?
- ..... Do you avoid exercise due to tiredness?
- ..... Do you sweat a lot or get excessively thirsty?
- ..... Do you sometimes lose concentration?
- ..... Is your energy less now than it used to be?

## Cardiovascular Profile

- ..... Is your blood pressure above 140/90?
- ..... Is your pulse after 15 min rest above 75?
- ..... Are you more than 14lbs (7kg) over your ideal weight?
- ..... Do you smoke more than 5 cigarettes a day?
- ..... Do you do less than 2 hrs exercise per week?
- ..... Do you eat more than 1 spoon of sugar a day?
- ..... Do you eat meat more than 5 times a week?
- ..... Do you have more than 2 alcoholic drinks per day?
- ..... Is there a history of heart disease in your family?

## Digestion Profile

- ..... Do you chew your food thoroughly?
- ..... Do you sometimes suffer from bad breath?
- ..... Are you prone to stomach upsets?
- ..... Do you often get a burning sensation in your stomach?
- ..... Do you find it difficult digesting fatty foods?
- ..... Do you occasionally use indigestion tablets?
- ..... Do you suffer from flatulence or bloating?
- ..... Do you experience anal irritation?
- ..... Do you have a bowel movement daily?
- ..... Do your stools float?

## Immune Profile

- ..... Do you get more than 3 colds per year?
- ..... Do you find it hard to shift an infection (cold or otherwise)?
- ..... Are you prone to thrush or cystitis?
- ..... Do you often take antibiotics more than twice a year?
- ..... Is there a history of cancer in your family?
- ..... Have you ever had any growths or lumps biopsied?
- ..... Do you have any inflammatory disease such as eczema asthma or arthritis?
- ..... Do you suffer from hay fever?
- ..... Do you suffer from allergy problems?
- ..... Have you had a personal loss in the past year?

## Allergy Profile

Do you suffer from any of the following? Please underline. Nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, frequent bloatedness, facial puffiness.

Do you have any allergies?..... If so what

.....  
State type of reaction.

.....  
Have they been tested?

.....  
What food or drinks would you find hard to give up?

## Additional questions for women only

- ..... Are you pregnant? If so how many weeks .....
- ..... Are you trying to become pregnant?
- ..... Have you ever had a miscarriage?
- ..... Do you have a IDU fitted, or use the birth control pill? State which.....
- ..... Are your periods regular?
- ..... Are you post menopausal?
- ..... Do you suffer from any pre-menstrual bloatedness, tiredness, irritability, depression, breast tenderness, headaches. (please underline)

## DIET ANALYSIS

Please tick the questions to which you would answer “yes” or fill in the “number of times” you eat the food referred to in the question.

- 1.....Were you breast fed?
- 2.....Was a significant percentage of your diet as a child high in fatty foods and sugar?
- 3.....Do you go out of your way to avoid foods containing preservatives or additives?
- 4.....Do you avoid foods which contains sugar?
- 5.....How many teaspoons of sugar do you add to food/drinks each day?
- 6.....Do you use salt in your cooking?
- 7.....Do you add salt to your food?
- 8.....How many coffees do you drink each day?
- 9.....How many cups of tea do you drink each day?
- 10.....How many times per week do you have meals containing fried food?
- 11.....How many packets of instant or fast food do you eat each week?
- 12.....How many times a week do you eat chocolate or confectionary?
- 13..... What percentage of your diet is raw fruit and raw vegetables?
- 14..... Do you wash fruit and vegetables before eating?
- 15..... Do you normally eat white rice and flour?
- 16..... How many cans of food do you eat per week?
- 17..... How many slices of bread or rolls do you eat each week?
- 18..... How many pints of milk do you drink each week?
- 19..... How many times a week do you eat red meat? (beef, pork, lamb or game)
- 20..... How many times a week do you eat white meat? (poultry, fish)
- 21..... What is your usual alcoholic drink?  
.....
- 22..... How many glasses do you drink per week?
- 23..... How many times a week do you eat live yoghurt?
- 24..... Do you use a water filter or drink bottled water instead of tap water?
- 25..... Do you frequently eat under stressful conditions or on the move?
- 26..... Does your job involve eating out a lot?
- 27..... How would you describe your appetite?  
a) poor                      b)average                      c)good

## MEAL PATTERN

Write down all the food and drinks consumed over (the next) two days, starting today. Please add as much information as possible including quantities eaten, brand names and whether the food is fresh or packaged, refined or natural.

### Day 1

---

**Breakfast**.....  
.....

**Lunch**.....  
.....

**Dinner**.....  
.....

**Snacks/Drinks**.....  
.....

### Day 2

---

**Breakfast**.....  
.....

**Lunch**.....  
.....

**Dinner**.....  
.....

**Snacks/Drinks**.....  
.....

**Are these two days representative of your usual eating habits? If not, what is a more usual day?**

**Breakfast**.....  
.....

**Lunch**.....  
.....

**Dinner**.....  
.....

**Snacks/Drinks**.....  
.....

The simplest way to pay for your assessment is via **PayPal** on our website [www.eatingforbeauty.co.uk](http://www.eatingforbeauty.co.uk) (click Gold).

However you may pay by cheque if you prefer. (Please note that this method will take longer to process) Cheques are made payable to "Eating For Beauty" Send to:

**Eating For Beauty**  
**35 Barkers Road**  
**SHEFFIELD**  
**S7 1SD**

Alternatively, you may telephone us on:  
**0114 2551345** and pay by credit/debit card.