



UrBalance Questionnaire

The questionnaire is designed to provide your nutritionist with the information necessary to build a nutritional programme specifically tailored to your needs. Please answer the questions as accurately as you can.

Client Details

First Name:..... Last Name:.....

Address:.....

.....

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

Telephone Number: (Day)..... (Evening)

Mobile: E-mail:.....

Occupation:..... Date of Birth:

Weight (without clothes):..... Height (without shoes):..... Blood group (if known)

G.P./Psychiatrist name:..... Telephone Number:

Address:

Name and phone of relative or other Support Person (if appropriate):.....

Health Profile

Please list all the problems you would like to clear up and indicate for how long you have had these problems eg: depression 3 years (continue on a separate sheet if you need more space)

Health problem	Duration
1.
2.
3.
4.

Under what circumstances do these problems improve?

Under what circumstances do they get worse?

List other illnesses that you have had in the past ten years:

.....

What operations have you had?

Blood pressure (if you know): Pulse.....

Family History

Relationship to client	Prone to following illness	Relationship to client	Prone to following illness
.....
.....
.....

SYMPTOM ANALYSIS

Each symptom in this section is associated with a nutritional deficiency. Tick in the box corresponding to the condition you often suffer from. Some symptoms are repeated. Please make a tick in all cases relevant to you.

Mouth ulcers	Lack of energy	Dry rough skin
Poor night vision	Diarrhoea	Dry eyes
Acne	Insomnia	Poor memory
Frequent colds or infections	Headaches or migraines	Loss of hair or dandruff
Dry flaky skin	Poor memory	Excessive thirst
Dandruff	Anxiety or tension	Poor wound healing
Thrush or cystitis	Depression	PMS or breast pain
Diarrhoea	Irritability	Infertility
	Bleeding or tender gums	
Rheumatism or arthritis	Acne	Muscle cramps or tremors
Backache		Insomnia or nervousness
Tooth decay	Muscle tremors or cramps	Joint pains or arthritis
Hair loss	Poor concentration	Tooth decay
Excessive sweating	Burning feet or tender heels	High blood pressure
Muscle cramps or spasms	Nausea or vomiting	
Joint pain or stiffness	Lack of energy	Muscle tremors or spasms
Lack of energy	Exhaustion after light exercise	Muscle weakness
	Anxiety or tension	Insomnia or nervousness
Lack of sex drive	Teeth grinding	High blood pressure
Exhaustion after light exercise		Irregular heart beat
Easy bruising	Infrequent dream recall	Constipation
Slow wound healing	Water retention	Fits or convulsions
Varicose veins	Tingling hands	Depression
Loss of muscle tone	Depression and nervousness	
Infertility	Irritability	Pale skin
	Muscle tremors	Sore tongue
Frequent colds	Lack of energy	Fatigue or listlessness
Lack of energy	Flaky skin	Loss of appetite
Frequent infections		Heavy periods or blood loss
Bleeding or tender gums	Poor hair condition	
Nose bleeds	Eczema or dermatitis	Poor sense of taste or smell
Slow wound healing	Mouth over sensitive to hot or cold	White marks on finger nails
Red pimples on skin	Irritability	Frequent infections
	Anxiety or tension	Stretch marks
Tender muscles	Lack of energy	Pale skin
Irritability	Constipation	Acne or greasy skin
Poor concentration	Tender or sore muscles	Low fertility
'Prickly' legs	Pale skin	Tendency to depression
Poor memory		
Stomach pains	Eczema	Muscle twitches
Constipation	Cracked lips	Childhood 'growing pains'
Tingling hands	Prematurely greying hair	Dizziness / poor sense of balance
Rapid heart beat	Anxiety or tension	Fits or convulsions
	Poor memory	Sore knees
Burning or gritty eyes	Lack of energy	
Sensitivity to bright lights	Poor appetite	Family history of cancer
Sore tongue	Stomach pains	Signs of premature aging
Dull or oily hair	Depression	Cataracts
Eczema or dermatitis		High blood pressure
Split nails	Dry skin	Frequent infections
Cracked lips	Poor hair condition	
Cataracts	Prematurely greying hair	Excessive or cold sweats
	Tender or sore muscles	Dizziness or irritability after 6 h without food
	Poor appetite or nausea	Need frequent meals
	Eczema or dermatitis	Cold hands
		Drowsiness during the day
		Excessive thirst
		'Addicted' to sweet foods

LIFESTYLE ANALYSIS

Answer the following questions as yes (✓) or No (X) by placing the appropriate symbol in the corresponding boxes

Cardiovascular profile	Histamine Profile
Is your blood pressure above 140/90?	Encircle/underline the following that apply to you sleep over 8 hours, little sex drive, much body hair, infrequent colds, sluggish metabolism, slow to wake up, short toes and fingers, suspicious by nature, can tolerate pain, fat or 'well covered' 'morning person', strong sex drive, little body hair, family history of allergies, fast metabolism, long fingers and toes, tendency towards depression, don't put on weight
Do you smoke more than 5 cigarettes a day?	
Do you do less than two hours exercise a week?	
Do you eat more than one spoon of sugar a day?	
Do you eat meat more than 5 times a week?	
Do you usually add salt to your food?	
Do you have more than 2 alcoholic drinks a day?	
Stress Profile	Allergy Profile
Is your energy less now than it used to be?	Encircle/underline if you suffer from any of the following nasal problems, hay fever, eczema, dermatitis, asthma, migraine, irritable bowel syndrome, facial puffiness, frequent bloating, psoriasis
Do you feel guilty when relaxing?	
Do you have a persistent need for achievement?	
Are you unclear about your goals in life?	Please state any allergies you have
Are you especially competitive?	Have they been tested?
Do you work harder than most people?	What food or drink would you find hard to give up? (please state)
Do you easily become angry or have aggressive feelings?	
Do you often do 2 to 3 tasks simultaneously?	
Do you get impatient if people or things hold you up?	Mental Health Profile
Do you have difficulty getting to sleep?	Do you get forgetful or confused?
	Do you have frequent mood swings?
Glucose Tolerance Profile	Do you find it hard to deal with stress?
Do you need more than 8 hours sleep?	Do you get deep depression for no particular reason?
Are you rarely awake within 20 minutes of rising?	Do you see or hear things abnormally?
Do you need something to get you going in the morning like tea, coffee or cigarette?	Do you feel unreal?
Do you have tea, coffee, sugary food or drinks, or cigarettes at regular intervals during the day?	Do you get suicidal thoughts?
Do you often feel drowsy during the day?	Do you have compulsive or obsessive tendencies?
Do you get dizzy or irritable if you don't eat often?	Do you have extreme fears or paranoia?
Do you avoid exercise due to tiredness?	Do you have inner tension or 'driven' feeling?
Do you sweat a lot or get excessively thirsty?	Do you have dyslexia or learning difficulties?
Do you sometimes lose concentration?	Do you have good tolerance of alcohol?
Is your energy less than it used to be?	Do you suffer from palpitations or blackouts?
	Do you get excessive or night sweats?
Digestion Profile	Do you have itchy ears, frequent ear infections, ringing in the ears?
Do you chew your food thoroughly?	Are you addicted to any recreational drugs (cocaine, heroin, amphetamines, caffeine tablets)?
Do you sometimes suffer from bad breath?	Do you have a lack of drive or motivation?
Are you prone to stomach upsets?	Do you rarely initiate or complete a task?
Do you often get a burning sensation in your stomach?	Do you have difficulty learning new things?
Do you find it difficult digesting fatty foods?	Is your mental clarity or concentration decreasing?
Do you occasionally use indigestion tablets?	Do you have poor dream recall?
Do you suffer from flatulence and/or bloating?	Are you socially withdrawn?
Do you experience anal irritation?	Are you restless?
Do you have a bowel movement daily?	Have you spent a lot of time in a polluted environment?
Immune Profile	Questions for women only
Do you get more than 3 colds a year?	Are you pregnant?
Do you find it hard to shift an infection (e.g cold)?	If so state the number of weeks:
Are you prone to thrush or cystitis?	Have you ever had a miscarriage?
Do you often take antibiotics more than twice a year?	Do you have an IUD fitted or use birth control pills?
Is there a history of cancer in the family?	Are your periods regular?
Have you ever had any growths or lumps biopsied?	Are you post-menopausal?
Do you inflammatory disease—eczema, asthma, arthritis?	Do you suffer from premenstrual bloating, tiredness, irritability, depression, breast tenderness, headaches
Do you suffer from hay fever?	(please encircle/underline)
Do you suffer from allergy problems?	
Have you had a major personal loss in the last year?	

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

Were you breast fed?		How many slices bread or rolls do you eat per week?	
Was a significant part of your diet as a child high in fatty foods and sugar?		How many times a week do you eat red meat? (beef, pork, lamb, game)	
Do you avoid foods containing preservatives / additives?		How many cans of food do you eat per week?	
Do you avoid foods which contain sugar?		How many times a week do you eat white meat? (poultry, fish)	
How many teaspoons of sugar do you add to food/drinks each day?		What is your usual alcoholic drink?	
Do use / add salt in your cooking?		How many glasses do you drink a week?	
How many coffees do you drink each day?		How many pints of milk do you drink a week?	
How many cups of tea do you drink each day?		Do you drink filtered/bottled water instead of tap water?	
How many times a week do you have fried food?		Does your job involve eating a lot out?	
How many times a week do you eat chocolate or confectionary?		Do you frequently eat under stressful conditions or on the move?	
Do you wash fruit and vegetables before eating?		How would you describe your appetite?	
Do you normally eat white rice or flour?		a) poor b) average c) good	

Please write down all the foods and drinks consumed over the next 2 days, starting today. Include details like time of consumption, description of the foods, drinks, quantities eaten and whether the food is fresh, packaged.

DAY 1	DAY 2
Breakfast	Breakfast
Lunch	Lunch
Evening meal	Evening meal
Snacks / Drinks	Snacks / Drinks

Nutritional Supplements	Medication
Do you take any supplements on a regular basis? Include brand names and daily dosage.	Do you take any medicines? Include names and daily dosage

Terms of Engagement

All information is strictly confidential and UrBod will not be disclosed to any third party without the client's written consent.

Advice provided during the consultation is not intended as a substitute for professional medical advice and / or treatment. The client should always consult their GP or primary healthcare provider if they require medical attention or have persistent concerns or symptoms.

The client must inform their GP, dietician or other medical practitioner that they are receiving nutritional therapy and they are actively encouraged to discuss their nutritional strategy.

If the client is receiving specific treatment from their GP, or any other medical provider, they should tell them about any nutritional programme provided by a nutritional therapist.

This is necessary because of any possible interactions between medication and a nutritional / supplement programme.

It is important that the client discloses to their nutritional therapist any medical diagnosis, medications, drugs or food / herbal supplements that they are taking, as this may affect the nutritional programme.

Nutritional advice will be individually tailored to support diagnosed conditions and/or health concerns identified and agreed during the consultation, however, there is no guarantee that health concerns will be resolved. The aim of the consultation is to assess and address the underlying causes of an individual's ill health.

If the client is unclear about the agreed nutritional therapy programme / food supplement doses / time period, they are required to contact us promptly for clarification.

The client must contact us should they wish to continue any specified supplement programme for longer than the agreed period.

Cancellation Policy

- Appointments cancelled 48 hours prior to your consultation can be rearranged at no extra cost.
- Cancellations made within 48 hours are charged at 50% of the consultation fee.
- Cancellations made within 24 hours are charged at 100% of the consultation fee.

Signature:.....

Date:.....

You will need to complete this questionnaire prior to your appointment and fax it to us on **0871 264 1648** or post to our mailing address.