My Nutrition Clinic

DIET AND SYMPTOM QUESTIONNAIRE

Name: Date:

1. Please indicate your current symptoms (in the last few months)

Symptom	Frequency				Severity		
	Never	Monthly	Weekly	Daily	Mild	Moderate	Severe
Rashes	☐	☐	☐	☐	☐	☐	☐
Hay fever	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐
Runny/blocked nose	☐	☐	☐	☐	☐	☐	☐
Post nasal drip	☐	☐	☐	☐	☐	☐	☐
Throat irritation/cough	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Mouth Ulcers	☐	☐	☐	☐	☐	☐	☐
Difficulty swallowing	☐	☐	☐	☐	☐	☐	☐
Nausea	☐	☐	☐	☐	☐	☐	☐
Vomiting	☐	☐	☐	☐	☐	☐	☐
Reflux	☐	☐	☐	☐	☐	☐	☐
Heartburn/indigestion	☐	☐	☐	☐	☐	☐	☐
Excessive wind/gas	☐	☐	☐	☐	☐	☐	☐
Bloating	☐	☐	☐	☐	☐	☐	☐
Pain/cramps	☐	☐	☐	☐	☐	☐	☐
Diarrhoea	☐	☐	☐	☐	☐	☐	☐
Constipation	☐	☐	☐	☐	☐	☐	☐
Variable bowel patterns	☐	☐	☐	☐	☐	☐	☐
Headache/Migraine	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐
Muscle/joint aches	☐	☐	☐	☐	☐	☐	☐
Bladder irritation	☐	☐	☐	☐	☐	☐	☐
Genital irritation	☐	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐	☐

2. Do you have any of the following?

	Current	Past	Never	Comments
High stress levels	☐	☐	☐	
Anxiety	☐	☐	☐	
Depression	☐	☐	☐	
Anorexia Nervosa	☐	☐	☐	
Bulimia Nervosa	☐	☐	☐	
Major weight loss	☐	☐	☐	

3. Do you currently have any other medical conditions?

4. Please list any medications or supplements you currently take:

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5. Do smells, fumes or environmental chemicals make you feel unwell?

E.g. perfumes, cleaning agents, pool chlorine, petrol, car fumes.

☐ Not at all ☐ A little ☐ A lot

6. Have you ever modified or restricted your diet? If yes, please explain:

Modification/restriction	Year modified	Reason for modifying	Source of advice (e.g. doctor, dietitian, naturopath, friend, family, internet, books)	Did it help? (comment)
☐ Vegetarian/Vegan				
☐ Belief based diet (Kosher, Halal, Hindu etc.)				
☐ Mediterranean diet				
☐ Low fat				
☐ Low calorie/low energy				
☐ Low carbohydrate				
☐ Gluten free diet				
☐ Wheat free diet				
☐ Milk free diet				
☐ Lactose free diet				
☐ Low FODMAP diet				
☐ An “Elimination” diet				
☐ Other (specify):				

7. Do you currently avoid any particular foods or drinks?

Food/drink	Symptoms of the worst reaction

8. What is your response to the following foods?

	OK	Dislike	Never Eat	React (please explain)
Cabbage	☐	☐	☐	
Garlic	☐	☐	☐	
Onion	☐	☐	☐	
Leek	☐	☐	☐	
Legumes	☐	☐	☐	
Pear	☐	☐	☐	

9. At present, how much do your symptoms impact your quality of life?

☐ Not at all ☐ A little ☐ A lot

10. Do you have any other comments you would like to add?

Please record the current typical foods, meals and drink you consume, including spreads, sauces, spices, stocks, sugar.

	Check list	How much, how often?
Breakfast	Water	
	Tea	
	Coffee	
	Milk (cows, soy, almond, rice)	
Morning snack	Juice	
	Cordial	
	Soft drink	
	Alcohol	
	Other drinks (shakes, sports, energy drinks etc.)	
Lunch	Cheese	
	Yogurt	
	Crackers	
	Biscuits/cakes	
Afternoon snack	Chocolate	
	Nuts/seeds	
	Lollies	
	Chewing gum/mints	
	Chips/crisps	
Dinner	Dried Fruit	
	Sandwich fillings (spreads, meats etc.)	
	Commonly eaten fruit	
	Commonly eaten vegetables	
Evening snack	Spices, stock cubes, sauces	
	Oil (specify)	
	Butter/Margarine	