

# QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 1 of 7



## HEALTH QUESTIONNAIRE

First Name: \_\_\_\_\_ Surname: \_\_\_\_\_

Address \_\_\_\_\_

Postcode: \_\_\_\_\_ Telephone (home): \_\_\_\_\_

\_\_\_\_\_ Telephone (work): \_\_\_\_\_

e-Mail: \_\_\_\_\_

Occupation (current, if working, or past): \_\_\_\_\_

GP's details: \_\_\_\_\_

I heard about your services from: \_\_\_\_\_

Consultant's Name (if undergoing specialist investigation/supervision): \_\_\_\_\_

Hospital Name: \_\_\_\_\_

Date of Birth (DOB): \_\_\_\_\_

Weight (now): Weight (previous): \_\_\_\_\_ Height: \_\_\_\_\_

### CURRENT HEALTH PROBLEMS AND CONCERNS:

PROBLEM	DURATION (from, to + if current)	TRIGGERS (if identifiable ) +/- or Influences	TREATMENT TRIED (orthodox/alternative remedies ) incl. dosage of medicines

If you require clarification concerning the information outlined above please contact your nearest qualified nutritional therapist for an appointment or contact: Ursula Fearn, MSc. Dip. ION BANT — Telephone: (01620) 826810, (07810) 673565 or (0131) 225 8092 or email: [ursula@nutri-ception.co.uk](mailto:ursula@nutri-ception.co.uk) (website: [www.nutri-ception.co.uk](http://www.nutri-ception.co.uk)).

# QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 2 of 7



Continued ...


## ANY OTHER MEDICAL PROBLEMS IN THE LAST 10 YEARS?

Any operations since birth?

---

Hereditary Profile:

---

---

Number (and sex) of children & siblings

---

Illnesses (Primary relations prone to if any, i.e. state son and/or daughter, brother and/or sister, mother and/or father in bracket):

---

---

- Tick to request specific (generic, i.e. brand name) supplement support programme advice or prescription with nutrition consultation.
- I prefer to purchase my own supplements.

# QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 3 of 7



## SYMPTOM ANALYSIS

Symptoms on the following pages are listed according to typical nutrient deficiency signs. Although some symptoms are repeated, please underline symptoms in all cases!

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Mouth ulcers                    | <input type="checkbox"/> Lack of energy                   | <input type="checkbox"/> Muscle cramps or tremors              |
| <input type="checkbox"/> Poor night vision               | <input type="checkbox"/> Diarrhoea                        | <input type="checkbox"/> Insomnia or nervousness               |
| <input type="checkbox"/> Acne                            | <input type="checkbox"/> Insomnia                         | <input type="checkbox"/> Joint pain or arthritis               |
| <input type="checkbox"/> Frequent colds or infections    | <input type="checkbox"/> Headaches or migraine            | <input type="checkbox"/> Tooth decay                           |
| <input type="checkbox"/> Dry flaky skin                  | <input type="checkbox"/> Poor memory                      | <input type="checkbox"/> High blood pressure                   |
| <input type="checkbox"/> Dandruff                        | <input type="checkbox"/> Anxiety and tension              | <hr/>  |
| <input type="checkbox"/> Thrush cystitis                 | <input type="checkbox"/> Depression                       | <input type="checkbox"/> Muscle tremors or spasms              |
| <input type="checkbox"/> Diarrhoea                       | <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Muscle weakness                       |
| <hr/>  | <input type="checkbox"/> Bleeding or tender gums          | <input type="checkbox"/> Insomnia or nervousness               |
| <input type="checkbox"/> Rheumatism and arthritis        | <input type="checkbox"/> Acne                             | <input type="checkbox"/> High blood pressure                   |
| <input type="checkbox"/> Back ache                       | <hr/>   | <input type="checkbox"/> Irregular Heart Beat                  |
| <input type="checkbox"/> Tooth decay                     | <input type="checkbox"/> Muscle cramps or tremors         | <input type="checkbox"/> Constipation                          |
| <input type="checkbox"/> Hair loss                       | <input type="checkbox"/> Apathy                           | <input type="checkbox"/> Fits or convulsions                   |
| <input type="checkbox"/> Excessive sweating              | <input type="checkbox"/> Poor concentration               | <input type="checkbox"/> Hyperactivity                         |
| <input type="checkbox"/> Muscle cramps or spasms         | <input type="checkbox"/> Burning feet or tender heels     | <input type="checkbox"/> Depression                            |
| <input type="checkbox"/> Joint pain or stiffness         | <input type="checkbox"/> Nausea or vomiting               | <hr/>  |
| <input type="checkbox"/> Lack of Energy                  | <input type="checkbox"/> Lack of energy                   | <input type="checkbox"/> Pale skin                             |
| <hr/>  | <input type="checkbox"/> Exhaustion after light exercise  | <input type="checkbox"/> Sore tongue                           |
| <input type="checkbox"/> Lack of sex drive               | <input type="checkbox"/> Anxiety or tension               | <input type="checkbox"/> Fatigue or listlessness               |
| <input type="checkbox"/> Exhaustion after light exercise | <input type="checkbox"/> Teeth grinding                   | <input type="checkbox"/> Loss of appetite or nausea            |
| <input type="checkbox"/> Easy bruising                   | <hr/>   | <input type="checkbox"/> Heavy periods or blood loss           |
| <input type="checkbox"/> Slow wound healing              | <input type="checkbox"/> Infrequent dream recall          | <hr/>  |
| <input type="checkbox"/> Varicose veins                  | <input type="checkbox"/> Water retention                  | <input type="checkbox"/> Poor sense of taste + smell           |
| <input type="checkbox"/> Loss of muscle tone             | <input type="checkbox"/> Tingling hands and carpel tunnel | <input type="checkbox"/> White marks on at least 2 fingernails |
| <hr/>  | <input type="checkbox"/> Depression or nervousness        | <hr/>  |
| <input type="checkbox"/> Infertility                     | <input type="checkbox"/> Irritability                     | <input type="checkbox"/> Frequent infections                   |
| <hr/>  | <input type="checkbox"/> Muscle cramps or tremors         | <input type="checkbox"/> Stretch marks                         |
| <input type="checkbox"/> Frequent colds                  | <input type="checkbox"/> Lack of energy                   | <input type="checkbox"/> Acne or greasy skin                   |
| <input type="checkbox"/> Lack of Energy                  | <input type="checkbox"/> Flaky Skin                       | <input type="checkbox"/> Poor Fertility                        |
| <input type="checkbox"/> Frequent Infections             | <hr/>   | <input type="checkbox"/> Poor Wound Healing                    |
| <input type="checkbox"/> Bleeding or Tender Gums         | <input type="checkbox"/> Poor Hair Condition              | <input type="checkbox"/> Depressive Tendency                   |
| <input type="checkbox"/> Easy Bruising                   | <input type="checkbox"/> Eczema or Dermatitis             | <input type="checkbox"/> Poor Appetite                         |
| <input type="checkbox"/> Nose Bleeds                     | <input type="checkbox"/> Mouth Sensitive to cold or hot   | <hr/>  |
| <input type="checkbox"/> Slow wound healing              | <input type="checkbox"/> Fingernails anxiety/tension      | <input type="checkbox"/> Muscle twitches                       |

If you require clarification concerning the information outlined above please contact your nearest qualified nutritional therapist for an appointment or contact: Ursula Fearn, MSc. Dip. ION BANT — Telephone: (01620) 826810, (07810) 673565 or (0131) 225 8092 or email: [ursula@nutri-ception.co.uk](mailto:ursula@nutri-ception.co.uk) (website: [www.nutri-ception.co.uk](http://www.nutri-ception.co.uk)).

## QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 4 of 7



- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Red pimples on skin    | <input type="checkbox"/> Lack of energy          | <input type="checkbox"/> "Growing pains" in childhood         |
| <hr/>   | <input type="checkbox"/> Constipation            | <input type="checkbox"/> Poor sense balance or dizzy          |
| <input type="checkbox"/> Tender muscles         | <input type="checkbox"/> Tender or sore muscles  | <input type="checkbox"/> Fits or convulsions                  |
| <input type="checkbox"/> Eye pains              | <input type="checkbox"/> Pale skin               | <input type="checkbox"/> Sore knees                           |
| <input type="checkbox"/> Irritability           | <hr/>  | <hr/>   |
| <input type="checkbox"/> Poor concentration     | <input type="checkbox"/> Eczema                  | <input type="checkbox"/> Family history of cancer             |
| <input type="checkbox"/> "Prickly" Legs         | <input type="checkbox"/> Cracked Lips            | <input type="checkbox"/> Cataracts                            |
| <input type="checkbox"/> Poor memory            | <input type="checkbox"/> Premature greying hair  | <input type="checkbox"/> High blood pressure                  |
| <input type="checkbox"/> Stomach pains          | <input type="checkbox"/> Anxiety and tension     | <input type="checkbox"/> Frequent infections                  |
| <input type="checkbox"/> Constipation           | <input type="checkbox"/> Poor memory             | <input type="checkbox"/> Premature ageing signs               |
| <input type="checkbox"/> Tingling hands         | <input type="checkbox"/> Lack of energy          | <input type="checkbox"/> Excess sweating                      |
| <input type="checkbox"/> Rapid heart beat       | <input type="checkbox"/> Poor appetite           | <input type="checkbox"/> Irritable + shaky/dizzy without food |
| <hr/>   | <input type="checkbox"/> Stomach pains           | <input type="checkbox"/> Drowsy during day                    |
| <input type="checkbox"/> Burning or gritty eyes | <input type="checkbox"/> Depression              | <input type="checkbox"/> Cold hands                           |
| <input type="checkbox"/> Sore tongue            | <hr/>  | <input type="checkbox"/> Excess thirst                        |
| <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Dry skin                | <input type="checkbox"/> "Addicted" to sweet foods            |
| <input type="checkbox"/> Dull or oily hair      | <input type="checkbox"/> Poor hair condition     | <input type="checkbox"/> Need for stimulants/snacks to boost  |
| <hr/>   | <input type="checkbox"/> Premature grey hair     | <hr/>   |
| <input type="checkbox"/> Eczema or dermatitis   | <input type="checkbox"/> Tender or sore muscles  | <input type="checkbox"/> Dry or rough skin                    |
| <input type="checkbox"/> Split nails            | <input type="checkbox"/> Poor appetite or nausea | <input type="checkbox"/> Dry eyes                             |
| <input type="checkbox"/> Cracked lips           | <input type="checkbox"/> Eczema or dermatitis    | <input type="checkbox"/> Frequent infections                  |
|   |  | <input type="checkbox"/> Poor Memory                          |
|   |  | <input type="checkbox"/> Loss of hair or dandruff             |
|   |  | <input type="checkbox"/> Excessive thirst                     |
|   |  | <input type="checkbox"/> Poor wound healing                   |
|   |  | <input type="checkbox"/> PMS or breast pain                   |
|   |  | <input type="checkbox"/> Infertility                          |

# QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 5 of 7



## LIFESTYLE ANALYSIS

TICK THE BOX ON THE LEFT HAND SIDE OF THE STATEMENTS BELOW THAT APPLY TO YOU AND CIRCLE ANY PART OF EACH STATEMENT THAT PARTICULARLY APPLIES TO YOU AND ADD IN INFORMATION IF YOU LIKE.

### CARDIOVASCULAR PROFILE

- My blood pressure is above 140/90.
- I am more than 1 stone (7kg) overweight.
- I smoke cigarettes, pipe, cigars or cannabis.
- I do less than 2 hours exercise a week.
- I eat red meat at least 5 times a week.
- I cook with or add salt to my food.
- I eat confectionery or take sugar in drinks at least 5 times per week.
- I eat less than 5 portions vegetables a day, excluding potatoes, beans and rice etc.
- I drink more than 14 units a week (man) or 7 units a week (woman) of alcohol.
- There is a history of heart disease in my family (e.g. angina, heart attack, atherosclerosis, intermittent claudication).
- I suffer from any form of diabetes.

### EXERCISE PROFILE

- I take exercise, that raises pulse substantially, for 20 minutes more than 3 times a week.
- My work involves strenuous physical activity.
- I play sport regularly (e.g. soccer, squash, ski or snow sports, work out etc.).
- I have physically tiring hobbies, e.g. gardening etc.
- I am addicted to exercise or gym routines?

### POLLUTION AND TOXICITY RISK PROFILE

- I live (or take exercise) in a city, busy town, near a main road, incinerator or industrial complex.
- I spend more than 2 hours a week in traffic.
- Do you smoke (have you smoked) or do you spend your leisure and work time in a smoky atmosphere?
- I buy more than 50% non-organic food and drink.
- I use unfiltered tap water to make meals or drinks more than 50 % of the time.
- I drink more than 7 units of alcohol a week or have in the past.
- I take (have taken) medication or street drugs. State: \_\_\_\_\_
- I am exposed to chemicals at work (e.g. solvents, disinfectants or cleaning fluids, agrochemicals, photographic or printing fluids or powders).
- I have been exposed to home and garden pollution in the last year (e.g. paint fumes, pest eradication, re-decorating, paint stripping, photographic solutions, mould treatments, fungicides, herbicides or insecticides etc.).
- I have recently had dental work involving amalgam fillings or parts thereof, being removed or added.
- I regularly eat tuna or swordfish and/or other canned foods.
- I suffer from constipation (i.e. empty bowels less than 1x per day).
- I am sensitive to fumes (e.g. traffic, paint perfume, cleaning fluids etc.).
- I have headaches more than 1x pcm or frequently, feel hung-over or suffer "brain fog" without alcohol.
- I suffer from skin rash, acne, spots.

---

If you require clarification concerning the information outlined above please contact your nearest qualified nutritional therapist for an appointment or contact: Ursula Fearn, MSc. Dip. ION BANT — Telephone: (01620) 826810, (07810) 673565 or (0131) 225 8092 or email: [ursula@nutri-ception.co.uk](mailto:ursula@nutri-ception.co.uk) (website: [www.nutri-ception.co.uk](http://www.nutri-ception.co.uk)).

## QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 6 of 7



### **ADRENAL STRESS PROFILE**

- I feel fatigued after a good night's sleep and have difficulty getting up in the morning.
- I suffer from insomnia (e.g. wake early or have trouble falling asleep at night).
- I suffer from stress intolerance (e.g. quickly irritated, easily enraged and shout or fly off the handle).
- I feel light headed when I stand up quickly (e.g. from a bed or chair).
- I am experiencing a decrease in libido and sex drive.
- I suffer from (please underline): poor memory, losing train of thought, indecisiveness, fuzzy head.
- I use compulsive behaviour (e.g. binge eating, drugs or cigarettes) to deal with stress load.
- I use sugary snacks, caffeinated drinks (e.g. coke, tea, coffee), cigarettes and or chocolate to keep me going through the day and avoid energy slumps.
- I experience an energy slump in the day. Time period: \_\_\_\_\_
- I suffer from PMS symptoms (e.g. irritation, carbohydrate craving) or I have menopausal hot flushes.
- I crave salty food or suffer from water retention (please underline).

### **GLUCOSE TOLERANCE/ DYSGLYCAEMIA PROFILE**

- I suffer mood swings or irritability, especially when a meal is late or skipped.
- I crave sweet, starchy foods or alcohol.
- I suffer energy dips (e.g. feel low in energy, even drowsy in the day after meals or mid afternoon and use caffeinated drinks, cigarettes or sugary snacks to pick you up).
- I suffer from excess sweating, unusual thirst or frequent passing of urine (e.g. at night).
- I have primary relations (brother or sister, father or mother) with PCO, polycystic ovary disease or diabetes.
- I am at least 2 stone (14kg) over weight and/or have an apple shape (i.e. fat deposits on your tummy rather than thighs and bum).
- Blood lipid profile or cholesterol profile from my GP shows a high level of triglyceride fats or sugar fats.
- I suffered form gestational diabetes (i.e. during pregnancy and/or had a baby over 9lbs in weight).
- I do less than 3 lots of pulse raising exercise sessions (of 20 minutes) per week.

### **DIGESTIVE PROFILE**

- I suffer from bad breath.
- I have less than 1 bowel movement a day or suffer from diarrhoea, or both.
- I suffer from indigestion. Trigger, if known: \_\_\_\_\_
- I regularly take medication, prescribed or over the counter, for indigestion.
- I had food poisoning or a major stomach upset within last 5 years at home or abroad.
- I suffer form digestive bloating or wind. Suspected triggers (if known): \_\_\_\_\_
- I suffer from anal irritation.
- My stools are light coloured.
- My stools float easily.
- My stools sink, like lead.
- My stools gently sink.

# QUESTIONNAIRE NCQ001

Last printed: 2005-06-14 (20:28:00)

Ursula Fearn - Page 7 of 7



## IMMUNE PROFILE

- I get more than 3 colds per year.
- I am prone to cystitis, UTIs or thrush.
- I use antibiotics for infections. State number of courses this year: \_\_\_\_\_ Last year: \_\_\_\_\_
- I have had a lump biopsied or removed. Year: \_\_\_\_\_ Body location: \_\_\_\_\_
- Family history cancer type (relation e.g. sister): \_\_\_\_\_
- I suffer from hayfever, asthma, eczema, arthritis(circle)
- I have had a loss or ending (e.g. death, relationship, work, pet) ... in the last year.
- I suffer from allergic symptoms (underline): post nasal drip, dark circles under my eyes, dermatitis, eczema asthma, migraine, IBS, facial puffiness, bloating.

Type of allergy or intolerance test undertaken: \_\_\_\_\_  
(e.g. vega, finger prick, rast, exclusion diet etc.)

Agency undertaking: \_\_\_\_\_  
(e.g. Holland + Barrett, Kinesiologist, York Lab, IWL etc.)

Result and year (e.g. wheat 1999): \_\_\_\_\_

## FEMALE HORMONE PROFILE

- I am pregnant. Week number: \_\_\_\_\_ since conception.
- I am trying to become pregnant. I have been trying for : \_\_\_\_\_ months. State if you intend to:
  - Suspend attempts whilst improving health using nutritional programme recommended.
  - Continue attempting pregnancy with nutritional support tailored to ensure safe levels of nutrients for a developing baby are not exceeded should pregnancy unexpectedly ensue.Detail any diagnosed barriers to fertility (e.g. low sperm count, fibroids, age, past miscarriage etc.)  
\_\_\_\_\_

State current or past fertility treatments used: \_\_\_\_\_

- Do you use a contraception method? State e.g. IUD, Pill Name :

Period info: Cycle Length: \_\_\_\_\_ Length of Bleed: \_\_\_\_\_  Heavy  Medium  Light

- I suffer from PMS symptoms (underline):  
bloating, breast tenderness, irritability, food craving, depression, headache.

Menopausal symptoms, if any. \_\_\_\_\_; Post Menopausal: \_\_\_\_\_

Medication used now and in the past to manage menopause or PMS symptoms: \_\_\_\_\_

THIS QUESTIONNAIRE ACKNOWLEDGES THE WORK OF  
NUTRI-LINK Ltd., NUTRI Ltd., ION AND PATRICK HOLFORD IN ITS DESIGN