



New

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Nutrition

Nutrition and Eating Disorders Clinic

Lifestyle Questionnaire

Name:

Phone:

Mobile:

STRICTLY PRIVATE AND CONFIDENTIAL

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General Instructions

Please read each question carefully before writing your answer down. If you experience difficulty in trying to answer any question then give yourself a few minutes and come back to it before you proceed onto the next section. The more accurate your answers are, the more information I will have in order to help you.

In some cases the questions will not be applicable to you, so in these cases you can place N/A in the space provided for the answers. There may also be questions you may not wish to answer at this time and that's fine too. You can leave these blank until you feel completely comfortable with giving me the information. I would like to re-iterate that this questionnaire is simply information for both of us. It may help you to notice something that you did not see before. I can evaluate what I learn with an open and non-judgmental mind, so that I can give you the best possible assistance with current issues.

Most questions are yes/no answer, however should you need to elaborate, please feel free to do so on separate sheets. **Remember there are no right or wrong answers, they are simply your answers as to what is going on with you.**

Please answer questions as honestly as you possibly can, as the object of the questionnaire is to furnish me with as much information as possible.

This helps me to help you.

Personal Details

Date: _____

Time: _____

Name: _____

Address: _____

Phone / Mobile: _____

Date of Birth: _____

Marital Status: _____

Children: _____

Occupation and level of job satisfaction:

Partner's Occupation:

Living Circumstances: _____

Hobbies and Interests: _____

Do you exercise: _____

How do you rate your relationships with others?

Person	Excellent	Good	Fair	Poor
Father	_____	_____	_____	_____
Husband / Partner	_____	_____	_____	_____
Male Friends	_____	_____	_____	_____
Female Friends	_____	_____	_____	_____
Children	_____	_____	_____	_____
Brothers	_____	_____	_____	_____
Sisters	_____	_____	_____	_____
Colleagues	_____	_____	_____	_____
Manager / Boss	_____	_____	_____	_____

How would you describe your temperament?

Details	Usually	Sometimes	Never
Humorous	_____	_____	_____
Moody	_____	_____	_____
Depressed	_____	_____	_____
Aggressive	_____	_____	_____
Angry	_____	_____	_____
Confident	_____	_____	_____
Optimistic	_____	_____	_____
Assertive	_____	_____	_____
Bored	_____	_____	_____
Patient	_____	_____	_____
Tolerant	_____	_____	_____
Judgemental	_____	_____	_____

Describe Your Religious / Spiritual Beliefs:

Write a few lines that best describe your childhood / teenage years

Write a few lines that best describe your Marriage / current relationship

Do you feel you have a purpose in life? If so, what is it?

Medical History

Please describe your general state of health at the moment?

Do you suffer from any of the following?

Tick if appropriate

Sore Throat	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	Thrush	<input type="checkbox"/>
Tiredness	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	Blood Pressure h/l	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	Panic Attacks	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	Rashes	<input type="checkbox"/>
The Shakes	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>
Depression	<input type="checkbox"/>	Early Waking	<input type="checkbox"/>
Feeling Cold	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>
Sweats / Hot Flushes	<input type="checkbox"/>	Stress	<input type="checkbox"/>
Dental Problems	<input type="checkbox"/>	Crying Bouts	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	Tension	<input type="checkbox"/>

Have you ever had any serious illness in the past? If so give details

Do you suffer from any known allergies?

Do you have any physical disabilities? Is so give details

Has any member of your family suffered from any of the following?

Please Tick

Diabetes	<input type="checkbox"/>	Migraine	<input type="checkbox"/>
Schizophrenia	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Eating Disorders	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
Alcoholism	<input type="checkbox"/>	Suicidal Tendencies	<input type="checkbox"/>

Have you ever taken any of the following medication?

Please tick

Tranquillizers	<input type="checkbox"/>	Sleeping Pills	<input type="checkbox"/>
Anti Depressants	<input type="checkbox"/>	Soft Drugs	<input type="checkbox"/>
Diet Pills	<input type="checkbox"/>	Hard Drugs	<input type="checkbox"/>

Do you smoke? If so, how many a day _____

Have you ever harmed yourself deliberately? Or felt the need to?

Have you ever consulted a Psychologist, Psychiatrist, Therapist, etc?

If so, give brief details

Have you ever tried to take your own life? If yes, when and why?

What is your attitude toward your current state of health?

Do you take any positive action to boost your current state of health?

Weight History & Body Image

WEIGHT: _____

HEIGHT: _____

WEIGHT

MAX WEIGHT: _____ WHEN & WHY _____

MIN WEIGHT: _____ WHEN & WHY _____

WHAT WOULD YOU SAY YOUR IDEAL WEIGHT IS AND WHY:

WHAT IS YOUR FAMILY'S WEIGHT DETAILS?

Person	Thin	Slim	Average	Fat	Obese
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____

ANY OTHER RELEVANT INFORMATION ABOUT WEIGHT OR DIETING IN YOUR FAMILY HISTORY?

How often do you weigh yourself? And why?

Body Image

How did you perceive your body as a child?

Were you ever teased about your weight?

When did you first think you had a weight problem?

If you are overweight why do you think this is so?

How do you feel about the way your body is proportioned?

How do you feel about the following parts of your body?

FACE: _____

NECK: _____

CHEST: _____

STOMACH: _____

THIGHS: _____

BOTTOM: _____

LEGS: _____

OTHER: _____

Where and with whom do you usually eat your meals?

Breakfast:

Lunch:

Dinner:

Who is responsible for preparing the food that you eat?

Do you eat healthy food? If not, why not?

Do you eat out often? If so, do you overeat when eating out?

How often do you attempt to diet?

How long do you usually maintain it?

At what age did you first embark on a diet? and why?

What methods have you used to restrict your weight in the past?

What method did you find most successful?

Do you feel you can eat sensibly when on a diet?

How old were you when your eating became a problem?

Was there a trigger at the time and if so what was it?

What constitutes a 'Bad Food Day' for you?

Have you ever... If so when and how often?

Starved _____

Made yourself sick _____

Spat food out _____

Taken Laxatives _____

Taken Diet Pills _____

Taken Diuretics _____

Over exercised _____

What type of lifestyle do you want?

What do you feel you need to do to have this lifestyle?

Any information about your lifestyle that may help me to achieve what you want?

Many thanks for taking the time to fill this questionnaire out



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For Wellbeing