



Greg de Jong: Physiotherapist &
Nutritionist

35 Beach Street Merimbula NSW 2548
Ph: 02 64951097 Fax: 02 64951397

Nutrition Assessment

By accurately and in detail completing this questionnaire I can make more efficient use of your therapy sessions. Thank you for your time in filling out the new patient questionnaire. You can leave out any questions/pages if you wish, or write more if you feel there is any other relevant information you need add.

Name:	DOB	
Address		
Phone:	Email	
If you have a smart phone is it Apple/Android/Microsoft based? <small>(Knowing this helps with providing information on Apps that may help with your Condition)</small>		
Private Health Fund:	No:	
Medicare No. (if on a Care Plan)		
Height:	Weight:	
Today's Date:	Your Doctor is?	

Please provide a brief description of your main reason for this appointment:

Outline how your weight has changed throughout life?

What diets have you tried and what have been their effects?

Have you previously lost weight, only to put it back on again?

Are there any foods you know you have an allergy/intolerance to?

Food	Reaction to Food

Are there any foods which you crave, feel addicted to, eat to excess?

Do you eat in response to your emotions; if so, what foods?

Weekly Food Intake

(Tick the Box that most reflects the serving frequency you eat the following food)

	1 or less	2-3/Wk	4-6/Wk	Daily	2-3/Day	3 or More
Beef						
Lamb						
Pork						
Chicken						
Other Poultry						
Fresh Fish						
Deep Sea Fish (Herring, Sardine, Mackerel, Tuna, Salmon etc)						
Other Seafood						
Eggs						

Citrus Fruit						
Stone Fruit						
Tropical Fruits						
Bananas						
Avocados						
Dried Fruits						
Tomatoes						

Leafy Greens						
Tuberous Veg. (Carrots, Parsnips, Beetroot, Squash etc)						
Cruciferous Veg. (Cauli, Broccoli, Cabbage, Brussel Spr.)						
Nightshades (Capsicum, Eggplant, Chilli)						
Starch Veg. (Potato, Sweet Potato, Corn)						
Onions/Leeks						
Mushrooms						

Peanuts						
Tree Nuts						

	1 or less	2-3/Wk	4-6/Wk	Daily	2-3/Day	3 or More
Beans						
Soy (including Tofu, Tempeh)						
Other Legumes (Lentils, Chick Peas)						

Milk						
Yoghurt						
Soft Cheese						
Hard Cheese						

Bread						
Pasta						
Breakfast Cereal						
Porridge (Oats)						
Rice						
Other Wholegrains						

Confectionaries						
Biscuits						
Cakes						
Chocolate						

Deep Fried Foods						
---------------------	--	--	--	--	--	--

Fruit Juice						
Soft Drink						
Tea						

How often do you add the following to your Food?

	<1/Day	1/Day	2/day	Every Main Meal	Main Meals & Snacks
Salt					
Sugar or substitutes					
Dressings or Sauces					

What percentage of your foods do you eat raw?

None	<20%	20-40%	40-60%	60-80%	80-100%
------	------	--------	--------	--------	---------

Do you attempt to avoid foods with artificial colours and flavours?	Yes/No
Do you buy organic when possible?	Yes/No
Do you wash your fruit and vegetables	Yes/No

FOOD BEHAVIOURS

Who does the cooking at Home?

What is the size of the following main meals?

Breakfast:	Small	Moderate	Large
Lunch:	Small	Moderate	Large
Dinner:	Small	Moderate	Large

How many snacks do you eat per day?

Do you often skip breakfast?	Yes/No
Do you regular skip other meals?	Yes/No
Which meal?	
Why?	

Do you get hungry between meals?	Yes/No
Do you binge eat at any time?	Yes/No
Do you regularly hurry down meals?	Yes/No

Do you eat out often?	1 or less	2-3/Wk	4-6/Wk	Daily
-----------------------	-----------	--------	--------	-------

When eating out do you make Healthy Food Choices	Yes/No
--	--------

Do you specifically avoid certain food components (Circle)

Gluten Casein Lactose Salicylates Amines FODMAPs

Other:

Why?

LIFESTYLE

Do you smoke and if so, how many/per day?	
---	--

How many hours sleep do you get per day? When do you go to sleep and wake up normally?

Do you follow a regular pattern of sleep or is it chaotic? Do you have problems with sleep and if so, what are they?

On average how long do you sit per day?	
---	--

On average how long do you stand per day?	
---	--

How long are you physically active without specifically exercising?	
---	--

Describe a normal exercise/sport week?
--

Are you satisfied with the amount of exercise you are doing? If not, what would you like to change?
--

Do you do any Relaxation/ Creative Visualisation/Meditation?
--

What Pleasure Activities do you enjoy and what are you Passionate about in life?
--

What Motivates you and what do you Reward yourself with?
--



Circle any **Medical Conditions** that you have or



Box Medical Condition where there is a **Family History?**

Heart Disease

High Blood Pressure

Low Blood Pressure

Diabetes

Asthma

COPD

Chronic Fatigue

Fibromyalgia

Cancer

Epilepsy

Depression

Anxiety

Osteoarthritis

Rheumatoid Arthritis

PMS

Menopause

Ankyl. Spondylitis

TMJ (Jaw) Problems

Hyperthyroid

SLE

Hypothyroid

Dementia

Alzhiemers Dis.

MS

Osteoporosis

Osteopenia

Mental Health

Incontinence

Irritable Bowel

IBD

Other Gastro (List)

Liver Disease

Psoriasis

Eczema

Lymphedema

Endometriosis

Migraines

Headaches

Anaphylaxis

ADHD/Autism

Any Other Medical Condition/Surgery?

Do you have any current illness such as cough, cold or flu? Yes/No

Is there any possibility you may be pregnant? Yes/No

List your Current Medication including Nutritional/Herbal Supplements?

GASTROINTESTINAL REVIEW

Answer the following Question by Ticking or circling the appropriate box.

	Always	Frequent	Occasional	Never
Hypoacidity				
Belching after Meals				
Gas after Meals				
Bad taste in mouth				
Bad Breath				
Poor protein digestion				
Loss of taste				

Hyperacidity				
Stomach Pain				
Hungry 1-2 hours after main meals				
Heartburn in lying				
Heartburn with spicy foods				
Antacid usage effective				
Milk reduces stomach pain				
Stress increases stomach symptoms				

Digestion (Dysbiosis/Enzymes/Candida)				
Bloating				
Cramping				
Nausea				
Undigested Foods in stools				
Fibre cause constipation				
Fruit causes discomfort				
Fat/yellow/greasy stools				
Antibiotic use				
Steroid use				
Long term contraceptives				

	Always	Frequent	Occasional	Never
Bowels				
Rectal Spasms				
Rectal Pain				
Diarrhea				
Constipation				
Abdominal pain relieved by bowel movements				
> 3 bowel motions/day				
Stress irritates bowels				
Bowel motion feels insufficient				
<p>What is the colour of your bowel motions?</p> <p>Do they float or sink?</p> <p>Do they smell? Yes/No</p> <p>Are they pebble like, thin and thready, mucousy, hard/soft?</p> <p>Have you ever seen blood in your stools? Yes/No</p> <p>If so, does your doctor know? Yes/No</p>				

Liver				
Pain under the right rib cage				
Abdominal Pain worse on Breathing				
Unexplained night itch				
Yellow skin or eyes				
Swollen feet or legs				

Candida				
White cover on tongue				
White cover vagina/under foreskin				

Hypoglycemia/ Food Intolerances				
Poor Concentration				
Headache				
Low Mood				
Hyperactivity/ Irritability				
Weakness				
Restless				
Low Energy				
Sleepiness 1-2 hrs after meals				
Sugar snack to pick yourself up				

Non-specific Joint or Muscle Aches				
Sore Throat				
Breathing Changes after meals				
Hives				
Red Ears				
Mouth Ulcers				
Bags beneath Eyes				
Nasal Polyps				
Cystitis				
Itchy Anus				
Itchy Genitals				
Bed Wetting				

Hyperglycemia				
Frequent Toileting				
>1 Night toileting				
Frequent Thirst				
Frequent Hunger				
Dizzy Spells				
Blurred Visions				
Slurred Speech				

Has your Doctor suggested or do you wish to trial any of the following diets (circle)?

Non-specific Healthy Eating Plan

Insulin Resistance

Weight Loss

Paleolithic

Autoimmune Paleo

Alkalisig

Renal

GAPS

Gluten/Casein

Body Ecology

SCO

Low Stimulant

Milk Chocolate Free

FODMAPS

Low Salicylates

Detox

Candida

Low Residual

Other _____