QUESTIONNAIRE FOR ASSESSING THE CLIENT'S HEALTH STATUS

# Please send filled questionnaire by e-mail: info@napsh.com

# 1. PERSONAL DETAILS:

Surname, first name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age (in full years): \_\_\_\_\_\_\_\_\_\_\_\_

Height (cm): \_\_\_\_\_\_\_\_ Current weight (kg): \_\_\_\_\_\_\_\_\_\_ Desired weight: \_\_\_\_\_\_\_\_\_\_

# 2. BASIC HABITS:

Sleep time: from \_\_\_\_\_ to \_\_\_\_\_ (average sleep duration): \_\_\_\_\_\_\_\_\_\_ hours

Do you fall asleep easily? ☐ Yes ☐ No

Do you wake up at night? ☐ Yes ☐ No (What time?): \_\_\_\_\_\_\_\_\_\_\_

Physical activity (type, frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? ☐ Yes ☐ No (which, how many times per week?): \_\_\_\_\_\_\_\_\_\_\_

Bad habits (alcohol, smoking): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of work: ☐ Sedentary ☐ Active ☐ Shift work ☐ Night shifts

# 3. HEALTH:

Food intolerance/allergies (products): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Surgical procedures (dates, type): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gallbladder deformity: ☐ Yes ☐ No

Dental status: ☐ Cavities ☐ Dead teeth (nerve removed) ☐ All fine

Skin problems: ☐ None ☐ Yes (which): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 4. CURRENT CONDITION:

Have you worked with a nutritionist before? ☐ Yes ☐ No (date, form): \_\_\_\_\_\_\_\_\_\_

Are you currently taking supplements/vitamins? Which? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (photo welcome)

Have you taken supplements in the past 3 months? ☐ Yes ☐ No (which?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a smart-/sports watch? ☐ Yes ☐ No

Psychological-emotional state (briefly describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you respond to stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you calm yourself after stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main health complaints at the moment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Main question for the consultation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 5. DIETARY PATTERN:

Do you eat at regular times? ☐ Yes ☐ No

Breakfast
Time: \_\_\_\_\_\_\_\_
Examples of breakfast:

Enough to keep you full until lunch? ☐ Yes ☐ No

Snacks after breakfast? ☐ Yes ☐ No (what?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch
Time: \_\_\_\_\_\_\_\_
Examples of lunch:

Enough to keep you full until dinner? ☐ Yes ☐ No

Snacks after lunch? ☐ Yes ☐ No

Dinner
Time: \_\_\_\_\_\_\_\_
Examples of dinner:

Snacks after dinner? ☐ Yes ☐ No

Typical snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Number of times per day: \_\_\_\_\_\_

Do you wake up hungry at night? ☐ Yes ☐ No

# 6. FOODS IN THE DIET:

Amount of vegetables per day (in cups or grams): \_\_\_\_\_\_\_\_\_\_\_

Cruciferous vegetables (white/red cabbage, broccoli, cauliflower, various radishes):
☐ Rarely ☐ Often (which?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fruit (pieces/day): \_\_\_\_\_\_\_\_\_\_\_

Berries (cups or grams/day): \_\_\_\_\_\_\_\_\_\_\_

Meat/poultry (times/week): \_\_\_\_\_\_\_\_\_\_\_

Fish (type, frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Organ meats: ☐ Yes ☐ No (which?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legumes (lentils, chickpeas, beans) (how often): \_\_\_\_\_\_\_\_\_\_\_

Fermented products (kimchi, sauerkraut, pickles): \_\_\_\_\_\_\_\_\_\_\_

Iodine sources (fish, seafood, seaweed, kelp) in the diet (which?): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reaction to onion/garlic: ☐ Yes ☐ No

What type of salt do you use? \_\_\_\_\_

# 7. FATS AND FLUIDS:

What oil do you use for frying? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For salads? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much oil per day (approx.): \_\_\_\_\_\_\_\_\_\_\_

Pure water (l/day): \_\_\_\_\_\_\_\_\_\_\_

Other drinks (type, amount): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 8. SYMPTOMS AND COMPLAINTS:

(check Yes or No)

Nausea after eating ☐ Yes ☐ No (after which products?): \_\_\_\_\_\_\_\_\_\_

Belching ☐ Yes ☐ No (air / odor?): \_\_\_\_\_\_\_\_\_\_

Bitter taste in mouth ☐ Yes ☐ No

Heartburn ☐ Yes ☐ No (how often?): \_\_\_\_\_\_\_\_\_\_

Bloating, flatulence ☐ Yes ☐ No (after what?): \_\_\_\_\_\_\_\_\_\_

Discomfort in side ☐ Right ☐ Left ☐ None

Daily bowel movements ☐ Yes ☐ No (type according to Bristol scale): \_\_\_

Constipation/diarrhea ☐ Yes ☐ No

White/grey coating on tongue ☐ Yes ☐ No (what color?): \_\_\_\_\_\_\_\_\_\_

Strong craving for sweets, chocolate, cocoa ☐ Yes ☐ No

Craving for unusual tastes (clay, chalk...) ☐ Yes ☐ No

Coffee > 2 cups/day ☐ Yes ☐ No

Hypertension / Hypotension ☐ Yes ☐ No

Dizziness when standing up ☐ Yes ☐ No

Weakness during physical exertion ☐ Yes ☐ No

Feeling cold easily ☐ Yes ☐ No

Bad breath/body odor ☐ Yes ☐ No (which: sour, chemical?): \_\_\_\_

Blocked nose without a cold ☐ Yes ☐ No

Excess mucus in nasal-throat cavity ☐ Yes ☐ No

Dark circles under eyes (shade?): \_\_\_\_\_\_\_\_\_\_\_

Muscle cramps, muscle pain ☐ Yes ☐ No

Nosebleeds ☐ Yes ☐ No (how often?): \_\_\_\_\_\_\_\_\_\_

Frequent sore throat, herpes, thrush (how often?): \_\_\_\_\_\_\_\_\_\_

Dry/flaky skin ☐ Yes ☐ No

Dandruff, fungus ☐ Yes ☐ No

FOR WOMEN WITH MENSTRUAL CYCLE:
Cycle length (days): \_\_\_\_\_\_

Duration of bleeding: \_\_\_\_\_\_

Pain/PMS (swollen breasts, mood swings, etc.): ☐ Yes ☐ No

Heavy bleeding ☐ Yes ☐ No

Diagnoses (PCOS, endometriosis, cysts, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# OTHER IMPORTANT INFORMATION:

(Write anything you find important here)