QUESTIONNAIRE FOR ASSESSING THE CLIENT'S HEALTH STATUS

# Please send filled questionnaire by e-mail: [info@napsh.com](mailto: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)