NUTRITIONAL NEEDS CONSULTATION

1. Contact details

Name		Address	
Telephone		Email	

2. Personal information

Age		Occupation	
Date of Birth		Family status	Single Married Divorced Other
Gender			
Height (cm)		Do you have children?	
Weight (kg)		Are you or could you be pregnant?	

3. Medical and health information

GP name		GP contact number	
GP address		Are you happy for us to contact your GP regarding your health needs?	

NUTRITIONAL NEEDS CONSULTATION

Are you taking any medication, supplements or herbal remedies?		Do you have any current or previous health concerns/ diagnoses?	
Do you have any family history of health conditions?		Do you currently access any complementary therapies?	

4. Lifestyle overview

Provide a summary of your lifestyle including information relating to both you social and work life

5. Hobbies and pastimes

Provide a summary of the activities you like to perform in your spare time

6. Symptoms checker

Do you experience any of the following symptoms (tick all the apply)?

DIGESTION

	Mild	Moderate	Severe
Bloating			
Constipation			
Diarrhoea			
Fluid retention			
Heartburn			

NUTRITIONAL NEEDS CONSULTATION

	Mild	Moderate	Severe
Nausea			
Stomach cramps			
Ulcers			
Vomiting			
Other			

MUSCULAR-SKELETAL

	Mild	Moderate	Severe
Back pain/ sciatica			
Muscle cramps, tics or spasms			
Muscle weakness			
Numbness or tingling of legs, hands or feet			
Osteopenia/ Osteoporosis			
Poor balance			
Other			

SKIN, HAIR & NAILS

	Mild	Moderate	Severe
Acne			
Brittle nails			
Coarse or brittle hair			
Dandruff			

Dry or itchy skin			
Eczema			
Oily skin or hair			
Psoriasis			
Rashes			
Ridges on nails			
Rosacea			
White spots on nails			
Other			

STRESS & SLEEP

	Mild	Moderate	Severe
Anxiety			
Broken sleep			
Depression/ low mood			
Dizziness			
Fatigue			
Insomnia			
Memory loss			
Over-sleeping			
Paranoia/ hallucinations			
Other			

NUTRITIONAL NEEDS CONSULTATION

VASCULAR

	Mild	Moderate	Severe
Anaemia			
Bleeding gums			
Delayed wound healing			
High cholesterol/ atherosclerosis			
High/low blood pressure			
Hot flushes			
Poor circulation			
Other			

OTHER CONDITIONS

	Mild	Moderate	Severe
Headache			
Heavy, light or absent periods			
High blood pressure			
Loss of taste/smell			
Low blood pressure			
Overweight/obesity			
Recurrent colds/ viruses			
Recurrent infections			
Sight problems			

PILATESHD
Pilates Nutrition Wellness

Underweight			
Weight loss/gain			
Other			

7. Your diet and lifestyle

How many portions of fruit and vegetables do you eat on an average day?		How often do you eat out?	
How often do you cook at home?		How often do you eat take-away food?	
Do you have any dietary restrictions?		What are your preferred foods?	
Are there any foods you dislike or prefer not to eat?		Do you smoke? If so, how many per day?	
Do you drink alcohol? If so, how many units per week?*		How long have you been a smoker?	
On how many days do you drink alcohol? What do you drink?		How often do you exercise and for how long on average?	
What type of exercise do you participate in? (Select all that apply)	Cardiovascular Strength training Resistance training	Do you suffer from stress? If so, how would you rate your current stress levels? 1=No stress 10=Extreme stress	
How many hours' sleep do you get on average per night?		Do you suffer from any known allergies or intolerances?	

* For more information visit https://www.drinkaware.co.uk/tools/unit-and-calorie-calculator

NUTRITIONAL NEEDS CONSULTATION

My goals

What are your health goals?

For example, to have more energy, lose weight, prevent illness

Of the goals you have listed, which matters most to you and why?

PILATESHD
Pilates Nutrition Wellness

NUTRITIONAL NEEDS CONSULTATION

What actions will you take to achieve your goal (list up to five)?

1
2
3
4
5

FOOD DIARY

	Day	When I ate	What I ate	How much I ate*	My feelings or symptoms
Week 1	Mon				
	Tues				
	Weds				
	Thurs				

PILATESHD
Pilates Nutrition Wellness

FOOD DIARY

	Fri				
	Sat				
	Sun				

*Grams, servings etc.

Week 2	Day	When I ate	What I ate	How much I ate*	My feelings or symptoms
	Mon				

FOOD DIARY

	Tues				
	Weds				
	Thurs				
	Fri				

PILATESHD
Pilates Nutrition Wellness

FOOD DIARY

	Sat				
	Sun				

*Grams, servings etc.

PILATESHD
Pilates Nutrition Wellness

FOOD DIARY

	Day	When I ate	What I ate	How much I ate*	My feelings or symptoms
Week 3	Mon				
	Tues				
	Weds				
	Thurs				

PILATESHD
Pilates Nutrition Wellness

FOOD DIARY

	Fri				
	Sat				
	Sun				

*Grams, servings etc.

PILATESHD
Pilates Nutrition Wellness

Release Form

In an emergency, I agree for Pilates HD to share the above information with the following people/organisations)lease provide a name, address and contact number for each):

GP:

Preferred hospital:

Family/next of kin:

Other (if applicable):

Signed:

Date:

PILATESHD
Pilates Nutrition Wellness