

Please complete **by hand if possible** and ensure form arrives with me **THE WEEK BEFORE** our appointment.
 Include **ALL THE INFORMATION YOU KNOW** even if we have had recent discussions about your situation.
 If you haven't got access to a printer please email me at nutrition@dawnwaldron.com for an editable version.

Nutrition & Lifestyle Questionnaire

CONFIDENTIAL

Your full name		COMPLETE BY HAND NOT BY TYPING	
Date of birth (and age)	Date of diagnosis	Today's date	
Your contact address & postcode		How did you hear about me?	
GP name, address & postcode		Did we do exploratory chat?	
Daytime phone number	Mobile phone number		
Occupation	Email address		
Ethnic group/genetic background		Blood group	
Please provide as much of the following information as you can even if you have told me some of it in previous conversations.			
Age: puberty	Age: first full-term pregnancy	Age: menopause	Date of last period?
Height (cm) / Waist (cm)	Current Weight (kg)	Birth weight	Highest/lowest adult weight
Blood pressure	Fasting glucose/HbA1c	Vitamin D	Blood: HDL & Triglycerides
Type of Cancer: primary, grade, stage, metastatic spread and location, receptor status. Please tell me everything you know (even if we have already chatted) and include ALL diagnostics here, not in additional emails or pieces of paper.			
Any other diagnosed medical conditions? e.g. diabetes, heart disease, osteoporosis. History of breast problems? Cysts, lumps?			
Current health issues (cancer aside)? overweight, diabetes, indigestion, constipation, reflux, mood disorders, eczema, fatigue etc?			
Any other intermittent health or lifestyle issues that may impact our work together?			
Are you pregnant, breastfeeding or trying to conceive? YES/NO			
What support are you looking for from me?			

Your medical status

What scans and medical treatment have you had since diagnosis? (give dates)
What treatment are you currently having? (give dates)
What treatment are you due to have in future? (give dates)
Please share any other prognostic indicators e.g. tumour markers, oncoblot testing, BRCA status, recurrence score etc.
Have you had any unusual/abnormal blood test results? YES/NO Details
How would you describe your current state of health and feelings about cancer?
Are you happy with your medical treatment? YES/NO Details
Have you refused any medical treatment? YES/NO Details
How do you feel about your oncologist?
What other avenues are you exploring? Any other diet influences? What books have you read? Websites do you follow?
Please send copies of any recent test results for e.g. diagnostic reports or letters, functional tests, genetic tests, whole blood, cholesterol, blood glucose, PSA, scans, or any letters from your oncologist or GP with your form.

Medication

Please list **ALL** prescribed or self-administered drugs you regularly take, including painkillers. Use a separate sheet if necessary:

Medication name & brand	Dose	Condition being addressed	Frequency	Start date
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Your life so far How has your life unfolded to date? Have you been ill, when did it start, or is it chronic? When did you take medication, have surgery, dental work? Has your diet changed or evolved? When did you have babies, IVF, lose loved ones, change jobs, move house, experience stress or conflict or relationship breakdown. Have you been addicted, used drugs, been overweight, lost a lot of weight, or had an eating disorder? Periods of vegan/vegetarian? Please outline your significant life history below:

What was the health, diet, lifestyle, environment, of your mother during pregnancy with you? _____

Where did your mother live when pregnant / Where were you born? _____ / _____

Your Birth: Vaginal/Caesar Prem/Late Breast/Bottle Other issues _____

Age 0-2 years _____

Age _____

Age _____

Age _____

Age _____

Age _____

Age _____

Age _____

Age _____

At diagnosis _____

Now _____

Your General Health both now and in the past (continue on a separate page if necessary)

Digestive problems? e.g. IBS, constipation, diarrhoea, reflux, Crohns, colitis, food poisoning.	
Food allergies or intolerances? Long periods on a different diet? Eating disorder?	
ANTIBIOTICS: When did you last take - what type - what for?	Roughly how many times in your life?
What is your history of alcohol use, smoking and recreational drugs? Any other harmful habits?	
Hormonal problems? e.g. PMS, PCOS, infertility, endometriosis, missed periods, IVF, HRT oral contraceptive, etc.	
Do you have or have you ever had any problems with energy or metabolism? e.g. chronic fatigue, acute stress, narcolepsy?	
Do you have any weight issues? Difficulty gaining or losing weight, being under or overweight, obesity, eating disorder? Any medical intervention or advice about weight. If your weight has always been reliably stable please tell me that too.	
Do you have or have you ever had any problems with immune or inflammatory issues? e.g. sinusitis, otitis, tonsillitis, glandular fever, eczema, asthma, hives, anaphylaxis, autoimmune problems?	
Do you have or have you had any mood, mental or motivational health issues? e.g. depression, anxiety, lethargy etc.	
How much time do you realistically have to focus on diet and lifestyle changes?	
Tell me about the stress in your life: what are your biggest sources of stress and how do you handle it?	

Family health please tell me about the health of your family members (**PLEASE TICK for YES, leave BLANK for NO**):

	Mother	Father	Sister(s)	Brother(s)	Child 1	Child 2	Child 3	Child 4	Mother's mother	Mother's father	Father's mother	Father's father	Neices & Nephews
Age if still alive													
OR Age at death													
Addictions (alcohol, cigarettes, drugs)													
Allergies/asthma/eczema													
Alzheimer's/dementia													
Anxiety/depression/OCD													
Autoimmune Disease/MS													
Cancer													
Diabetes													
Digestive problems/IBS													
Genetic Disorders													
Heart Disease/hypertension/stroke													
Obesity/weight problems													
Psychiatric disorders													
Thyroid problems													
Other.....													

Life balance Please think about daily life. What are your areas of concern? Positives and negatives? Then please rate each one:
A = best ever **B** = working on it **C** = an area where you really struggle **D** = beyond repair **E** = not important to you

	What was it like before diagnosis...	and since diagnosis?	Rate
Sleep			
Exercise habits			
Toxic Exposure			
Habits /addictions			
Stress/Conflict			
Relationships			
Social life			
Work life/load			
Financial status			
Life purpose			
Fun/relaxation			
Inner thoughts			

Food choices

Please take your time to fill out this part of the form and provide as much information as possible.

What do you eat and drink...Please think about weekdays AND weekends too. If your diet is very different now please tell me about 'before' by printing this page twice and clearly marking the pages BEFORE AND AFTER .	
...when you wake up	
...breakfast	
...lunch	
...dinner	
...snacks	
...drinks tea, coffee, water, alcohol, etc?	
What factors are important to you when planning your food?	low fat, low carb, whole grain, unrefined, low sugar, low calorie, low GI, low cholesterol, organic, quick, free-range, fresh, grass-fed, easy, non-GMO, cheap, environmentally friendly, lots of flavour, not spicy
What is your idea of a super-healthy meal?	
How many meals/snacks do you eat and at what times in the day?	
What fats or oils do cook with?	
What are your favourite foods?	
What foods do you dislike?	
What foods do you crave?	
What would be hard to give up?	
What do you avoid/reduce for health or ethical reasons?	
What food do you avoid/worry about since cancer diagnosis?	
What do you eat/drink as treat?	
Any foods you're not prepared to eat?	
What will your find difficult about changing your diet? e.g. time, family constraints, cooking, shopping, likes/dislikes, strong views about food, non-negotiable etc.	

Supplements

Please list **ALL** supplements you take. Or state **NO SUPPLEMENTS**. If too many please list on a separate sheet or send photo.

Brand	Name	Dose	Taking since date	Recommended by/because
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Before & After Has anything significant changed in your life since diagnosis e.g. diet, lifestyle, work or home life, mood, alcohol, smoking etc.

Your Questions Please think about what you want to get out of our session, what are your burning questions, doubts etc. Tell me here:

Client Agreement - Please read this and consider carefully before signing below

I am keenly aware, and I'm sure you are too, that there is currently considered to be 'no cure' for cancer. Even though the NHS does its best via your oncologist there are no guarantees, and there is a possibility that some treatment may do more harm than good. Nutritional Therapy is no different: there is no guarantee that the work we do together will be effective, and a small chance that it may make things worse. I do not 'treat' cancer, my work is based on the understanding that a healthy body has an innate healing capacity. My aim is to give you information to restore your body as far as possible to equilibrium so that it can defend itself. I may encourage you to explore other avenues but I cannot recommend things which are beyond the scope of nutritional therapy. - ie diet and lifestyle habits which affect the nutrient status in your body. No diet can make up for a damaging lifestyle.

I am a trained and registered nutritional therapist, nutrigenetic counsellor and life coach - and a cancer survivor with a personal and professional interest in staying disease free. My work is primarily evidence based but I also use instinct, experience and common sense. Some health professionals and educated lay persons have different views, especially about cancer, and it is up to you to satisfy yourself whose advice you want to follow. I encourage clients to think very carefully before following any advice, to ask questions, do their own research and deal with dissonance.

Nutritional therapy is recognised as a complementary medicine - it is the application of nutrition science to promote health, performance and individual care; practitioners use a range of tools to assess and identify potential nutritional imbalances and how these may contribute to health concerns. This approach allows them to work with individuals to address nutritional balance and help support the body towards maintaining health. Practitioners never recommend it as a substitute for medical advice and/or treatment and always refer any client with 'red flag' signs or symptoms to their medical professional. Cancer is a 'red flag' symptom. Standards of professional practice in Nutritional Therapy are governed by the CNHC Code of Conduct.

You agree to:

- work with and maintain contact with your GP/oncologist and inform your medical team of any health concerns you may have
- tell your GP/oncologist and any other practitioners who are helping you about the nutrition strategy we have agreed together
- tell me about any medical diagnosis, medication, clinical trials, herbal medicine, or supplements
- let me know any changes to the above information for the duration of the time we are working together
- treat my advice as 'complementary' (in addition) to your medical treatment rather than 'alternative' (instead of)
- contact me as soon as possible if you are worried or unclear about any of the advice I have provided
- take personal responsibility for implementing the advice I provide, or for choosing not to

Please read all the notes above and sign this form to agree that our professional relationship will be based on the above understanding and indicate that you have disclosed all relevant information relating to your current state of health.

Signed _____ Date _____

Sending the form back to me

Please photograph, scan or send me your completed questionnaire to reach me by **the Friday before** our first appointment.

Post: 16 Modest Corner, Tunbridge Wells, TN4 0LS. Keep a copy and **DO NOT** send by any method that needs a **signature**.

Email: dawnwaldron@mac.com with **high resolution** scans or photos.

Storing your data

In order to provide you with advice I will store personal information which may include family and health history, medical and genetic data, address, gender, ethnicity, disability and lifestyle habits. While we are working together I will store information on paper and/or digitally on my desktop computer and in the cloud: password protected but not encrypted. Once we have completed our work together, all paper will be scanned, shredded, and recycled within 1 year. Digital records will be deleted after 8 years. You are entitled to request a copy of any information I hold about you. I may contact you by email with details of my services from time to time. If you are happy with this arrangement **please sign below**.

I understand and accept your information storage arrangements,

Signed _____ Date _____