Nutritional Assessment

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CENTER FOR NEUROLOGY & REHABILITATION

Please read the questions carefully and answer them honestly.

Personal information		
First name:	Last name:	Date of birth / age:
Relationship status:	Profession:	Country of birth:
Height (cm):	Weight (kg):	Is your weight stable: ☐yes ☐no
BMI:	Weight gain/loss in the last 3-6 months:	

Medical & dietary History	**YES**	**NO**
Do you suffer from any lifestyle diseases (type 2 diabetes, heart attack, stroke, obesity, overweight/obesity, etc.)? If yes, which: _____	☐	☐
Do any members of your immediate family suffer from a lifestyle disease (type 2 diabetes, heart attack, stroke, obesity, etc.)? If yes, which: _____	☐	☐
Do you take any medication? If yes, which ones: _____	☐	☐
Do you take any dietary supplements? If yes, which ones:_____	☐	☐
Have you ever had an eating disorder?	☐	☐
Do you have food allergies? If yes, which ones: _____	☐	☐
Do you drink coffee? Cups per day: _____	☐	☐
Do you drink tea? Cups per day: _____	☐	☐
Do you like softdrinks? Intake in liters per week: _____	☐	☐
Do you drink alcohol? Units per week: _____ (1x unit = 1 dl wine, 33 cl beer, 2 cl spirits)	☐	☐
Do you smoke cigarettes or use tobacco substitutes? Cigarettes per day: _____	☐	☐
Do you take any illegal drugs? If yes, which ones: _____	☐	☐

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Intestinal Health	YES	NO
Do you suffer from a gastrointestinal disorder?	☐	☐
If yes, which one:		
Do you have problems with flatulence?	☐	☐
Do you often feel nauseous?	☐	☐
Do you suffer from constipation?	☐	☐
Do you often have diarrhoea?	☐	☐
Do you suffer from reflux or heartburn?	☐	☐
Do you have frequent bowel movements?	☐	☐
How often? (daily, weekly, etc.) _____		

Mental Health

How would you describe your mental health?

Please describe your stress level on a scale of 1-9: _____

Sleep

How many hours do you sleep per night? hours

Do you feel rested after waking up?	☐	☐

How would you describe the quality of your sleep on a scale of 1-9? _____

Exercise / Sport

Do you consider yourself sufficiently active?	☐	☐

How would you rate your physical condition?

How many hours per week do you do regular sport? hours

What kind of sports/activities do you do?

Please describe your general energy level on a scale of 1-9: _____

Dietary information

Have you followed a specific diet(s) in your life?

On a scale of 1-9, how would you rate your knowledge/interest in nutrition? _____

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Do you have any dietary preferences/religious beliefs? (e.g. vegetarian, vegan, halal, etc.)?

How many meals do you eat per day, including snacks?

Approximately how many glasses of water (liter) do you drink per day? liters

Please describe a typical day in terms of your food intake:

	Food	Time
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Drink/Other		

Additional information

When did you last see your family doctor?

Please briefly explain why you would like a nutritional assessment and what you would like to achieve:

☐ I confirm that I have provided the correct information and that I consent to this information being used discreetly for the purposes of the programme.

Please send the completed questionnaire **prior to yur consultation**
to teletherapy@cereneo.ch.