

Client Consultation Form

iUCT41 – Diet and nutrition for complementary therapists

Centre name:	
Centre number:	
Learner name:	
Learner number:	
Date:	

Client name:		
Address:		
Profession:		
Telephone number:	Day:	
	Evening:	

Personal details:						
Age group:	Under 20 <input type="checkbox"/>	20 – 30 <input type="checkbox"/>	30 – 40 <input type="checkbox"/>	40 – 50 <input type="checkbox"/>	50 – 60 <input type="checkbox"/>	60+ <input type="checkbox"/>
Lifestyle:	Active <input type="checkbox"/>			Sedentary <input type="checkbox"/>		
Last visit to the doctor:						
GP address:						
Number of children: (If applicable)						
Date of last period: (If applicable)						

Personal information – (Select if/where appropriate):				
Muscular/skeletal problems:	Back <input type="checkbox"/>	Aches/pain <input type="checkbox"/>	Stiff joints <input type="checkbox"/>	Headaches <input type="checkbox"/>
Digestive problems:	Constipation <input type="checkbox"/>	Bloating <input type="checkbox"/>	Liver/gall bladder <input type="checkbox"/>	Stomach <input type="checkbox"/>
Circulation:	Heart <input type="checkbox"/>	Blood pressure <input type="checkbox"/>	Fluid retention <input type="checkbox"/>	Tired legs <input type="checkbox"/>
	Varicose veins <input type="checkbox"/>	Cellulite <input type="checkbox"/>	Kidney problems <input type="checkbox"/>	Cold hands and feet <input type="checkbox"/>
Gynaecological:	Irregular periods <input type="checkbox"/>	P.M.T. <input type="checkbox"/>	Menopause <input type="checkbox"/>	H.R.T <input type="checkbox"/>
	Pill <input type="checkbox"/>	Coil <input type="checkbox"/>	Other:	
Nervous system:	Migraine <input type="checkbox"/>	Tension <input type="checkbox"/>	Stress <input type="checkbox"/>	Depression <input type="checkbox"/>
Immune system:	Prone to infections <input type="checkbox"/>	Sore throats <input type="checkbox"/>	Colds <input type="checkbox"/>	Chest <input type="checkbox"/>
	Sinuses <input type="checkbox"/>			
Regular antibiotic/medication taken:				
Herbal remedies taken:				
Ability to relax:	Good <input type="checkbox"/>	Moderate <input type="checkbox"/>	Poor <input type="checkbox"/>	
Sleep patterns:	Good <input type="checkbox"/>	Poor <input type="checkbox"/>	Average no. of hours:	
Do you see natural daylight in your workplace?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you work at a computer?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, how many hours:	
Do you eat regular meals?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you eat in a hurry?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you take any food/vitamin supplements?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
How many portions of each of these items does your diet contain per day?	Fresh fruit:	Fresh vegetables:	Protein and source:	
	Dairy produce:	Sweet things:	Added salt:	Added sugar:
How many units of these drinks do you consume per day?	Tea:	Coffee:	Fruit juice:	Water:
	Soft drinks:	Others:		

Do you suffer from food allergies?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Bingeing?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Overeating?	Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Do you smoke?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many per day?	
Do you drink alcohol?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	How many units per day?	
Do you exercise?	None <input type="checkbox"/>	Occasional <input type="checkbox"/>	Irregular <input type="checkbox"/>	Regular <input type="checkbox"/>
	Types:			
What is your skin type?	Dry <input type="checkbox"/>	Oil <input type="checkbox"/>	Combination <input type="checkbox"/>	Sensitive <input type="checkbox"/>
	Dehydrated <input type="checkbox"/>			
Do you suffer/have you suffered from:	Dermatitis <input type="checkbox"/>	Acne <input type="checkbox"/>	Eczema <input type="checkbox"/>	Psoriasis <input type="checkbox"/>
	Allergies <input type="checkbox"/>	Hay fever <input type="checkbox"/>	Asthma <input type="checkbox"/>	Skin cancer <input type="checkbox"/>
Stress level: 1-10 (10 being the highest)	At work:	At home:		

Client profile – (To include any current issues):

Full diet plan taking into account the client's current lifestyle with a rationale for the plan – (To include products used):

Feedback to show evidence of the progression of the new diet:**Reflective practice:****Overall conclusion:****Date of diet:**

Start:

Finish:

Therapist/Learner signature: _____

Client signature: _____

Document History

Version	Issue Date	Changes	Role
v1	10/01/2020	First published	Qualifications Administrator