1. Please fill in the following data:

|  |  |
| --- | --- |
|  **Name, Surname** |  |
| **~~PESEL~~** | **Address** | **Current body mass / height** |
| **Skype login (***it concerns online consultations***)** |
| **Phone, e-mail address**nr tel.:e-mail: | **Reason and purpose of the visit** |
|  |
| **Physical activity** *(type of activity, number of hours per day and during the week)* | **What do you expect from a dietitian?** |
| **Chronic diseases** *(Hashimoto, diabetes, atherosclerosis, other)* |
| **Drugs and supplements** *(type, company, dose, how long used)* |
| **Food allergies** *(childhood / current)* |
| **Are there any problems with thyroid gut, intestines, allergies, obesity, cancer, etc. among close relatives?** |
| **For woman: the menstrual period: is it regular/ painful/**  |
| **What is your lifestyle -** *how many hours do you sleep, how many hours do you work, what do you do in your free time, how do you spend weekends, do you cook at home or eat in the city?* |
| **Stimulants -** *do you drink alcohol (how often), coffee (what kind, how often, with milk or sugar), energy drinks (how much, how often)? Do you smoke cigarettes (how many during the day, how many years)?* |
| **Do you reach for sweets after a meal?** *What kind?* |
| **Do you feel sleepy / sleeping after a meal?** |
| **Do you get rested / refreshed in the morning?** |
| **Do you often get sick / catch a cold?** |
| **What is your motivation to take on changes in nutrition (scale from 1 to 10)?** |

|  |  |  |  |
| --- | --- | --- | --- |
| SYMPTOMS | How often (ex. once a week) | SYMPTOMS | How often (ex. once a week) |
| recurrent conjunctivitis  |  | caries |  |
| excessive sweating |  | face swelling |  |
| headache |  | catarrh |  |
| migraine |  | sinus inflammation |  |
| insomnia / sleep problems |  | skin blemishes |  |
| fears |  | pruritus |  |
| depression |  | dry skin |  |
| chronic fatigue |  | acne |  |
| postprandial sleepiness |  | gray complexion |  |
| problems with concentration |  | the fragility of hair and nails |  |
| abdominal pain |  | dark circles under the eyes |  |
| heartburn |  | muscle pain |  |
| diarrhea |  | joint swelling |  |
| constipation |  | bone and joint pain |  |
| abdominal flatulence |  | abundant menstruation |  |
| dyspepsia |  | premenstrual syndrome |  |
| irritable bowel syndrome |  | menstrual cycle disorder |  |
| weight problems |  | breast cysts, uterus |  |
| water retention in the body |  | palpitations |  |
| chronic cough |  | memory problems |  |
|  |  |  |  |
|  |  |  |  |

1. Please mark the symptoms appearing in the table below and / or enter others in the free places.
2. Please fill out the following fields regarding gastrointestinal work carefully

|  |  |
| --- | --- |
| Have you got a problem with diarrhea or constipation?  |  |
| Flatulence after a meal (I have, I do not have, how often do they appear, what products are appearing on) |  |
| The smell of stool is unpleasant and irritating (yes, no, what smell - sour, metallic, sulfuric, smelly, different) |  |
| Stool color (brown, green, light, yellow, other) |  |
| Blood in the stool (yes, no, was in the past)I have "shooting" stools (yes, no, by what products) |  |
| After meals, I feel heaviness on the stomach (yes, no, on what products / meals) |  |
| How often antibiotics are taken |  |
| Gastric ulcers, inflammation of the intestines / stomach (they are, they were, was in the past) |  |
| Nausea, vomiting (yes, no) |  |

1. Has any diet been used for the last year (eg gluten-free, dairy-free, low-calorie, protein, vegetarian)? If so, please complete the following information:

|  |  |
| --- | --- |
| Type of diet used(name of the diet, whether it was arranged with the help of a specialist, what was the motivation) |  |
| The period when the diet was used(since when, till when) |  |

1. Please keep a nutritional journal for 3 consecutive days (preferably including one weekend day - holiday, free from work) to assess nutrition.

DAY 1, date and day of the week:
The hour that you got up:
The hour that you go to bed:

|  |  |  |  |
| --- | --- | --- | --- |
| Time of consumption | Type of meal and place of consumption | Products / meals | Quantity |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Frame of mind:

DAY 2, date and day of the week:
The hour that you got up:
The hour that you go to bed:

|  |  |  |  |
| --- | --- | --- | --- |
| Time of consumption | Type of meal and place of consumption | Products / meals | Quantity |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
| Frame of mind: |  |

DAY 3, date and day of the week:
The hour that you got up:
The hour that you go to bed:

|  |  |  |  |
| --- | --- | --- | --- |
| Time of consumption | Type of meal and place of consumption | Products / meals | Quantity |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Frame of mind:

**Thank you for filling up the questionnaire!**