This form should be completed before your appointment to assess with your dietetic assessmenrt.

Personal Information

Name _____

Date Of Birth _____

Tel/mobile _____

Email _____

PRE-ASSESSMENT
QUESTIONAIRE

Gender ☐ Height (cm) ☐

Weight (kg) ☐

Address _____

Town _____

County _____

Emergency contact _____ Tel/mobile _____

Medicines & Allergy informtion

☐ Do you have any allergies?

If yes, briefly outline in the space below

☐ Are you being treated any medicines, herbals or other therapies precribed by a Doctor, another practioner or purchased by yourself?

If yes, briefly outline in the space below

Let's find out a bit of background

Current sports & pastimes

Occupation _____

Previous occupation (if any) _____

Current activity level _____

Normal activity level _____

Historic activity level _____

Sports & pastimes you used to do

For safety, we'll need to ask you some quick questions about you medical history

Do you have, suffer from or are you .....

- ☐ High or low blood pressure?
- ☐ A problem with bleeding or blood clots? (including bruising or a stroke)
- ☐ Any skin conditions or reactions? (including reactions to metals in jewellery)
- ☐ Osteoporosis or brittle bones?
- ☐ Asthma, Emphysema, COPD or Bronchitis?
- ☐ Arthritis?
- ☐ Pregnant?
- ☐ Cancer or a blood disorder?
- ☐ Stress or anxiety?

Can you give us a bit of information on why you're visiting us?

Tell us, in your own words, what the problem is?

How much does it affect you (0-10)?

- ☐ Abnormal pain? (Either now or in the past)

If yes, can you tell us a bit more

- ☐ Have you had any surgery in the past year? (including dental work)

(If yes, please tell us a bit more about it)

- ☐ Do you have a condition not covered by the above? (Please use the box below)

How long ago did it start? _____

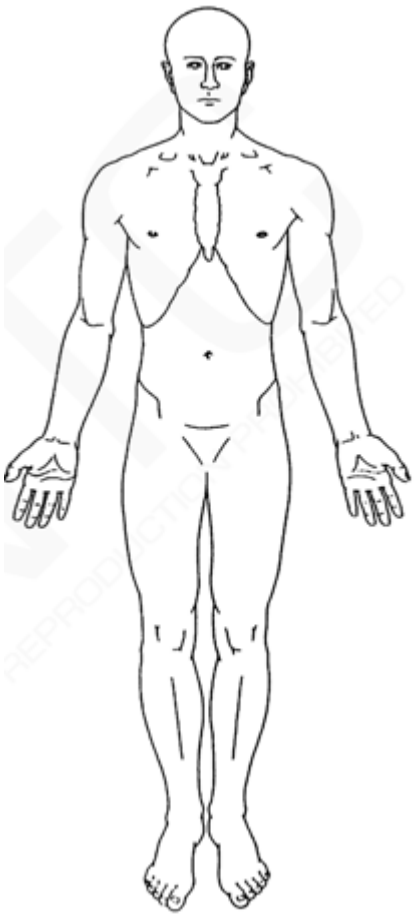
Can you remember what you were or had been doing? Was it something different to normal?

Does it stop you doing anything you would normally do?

How bad is the pain/discomfort (0-10)?

Can you describe the pain/discomfort?

Please mark the on the chart below where the problem is



And finally.....

What outcome from treatment would you hope for?

Signature:
(Patient/Guardian)

Date: