Dr Anna Hattingh

Integrative Health Dietary Questionnaire

Please print out and return before your consultation/bring along to your first visit.

Client Information

1. Full Name:
2. Age:
3. Gender:
4. Height:
5. Weight:
6. Primary Health Concern(s) (if any):

Section 1: Family history

Father: age, cause of death if relevant, health in general

Mother: age, cause and age of death if relevant, health in general

Do you have siblings, their age and your position in the family (eg middle child)

Do you know of any chronic or serious health conditions in your family? Please list.

Section 2: Birth history

DOB:

Were you born via: Normal vaginal delivery/ cesarean section/ assisted birth: forceps/ventouse (suction)

Did your mother receive antibiotics during pregnancy/birth/breastfeeding?

Were you breastfed? How long for?

Did you receive vaccinations as a baby?

Do you know if/think your mother was happy during her pregnancy with you?

Section 3: Childhood history

Do you have mostly happy memories of childhood?

Would you say your family life was happy, or dysfunctional?

What type of schools did you attend?

Did you fit in at school?

Did you have childhood vaccinations? Yes/ no

Have you had any chronic/serious health issues as a child? Please list/explain

Have you had any health issues as a young adult?

Did you ever need to take medication? Please list

Section 4: Environmental history

Did you grow up in a city/ farm/ country?

Were there any factories around close to where you grew up/ lived at some point?

Have you ever lived in old homes that were renovated/re-painted?

Are you aware if you had mould exposure? (damp living environment)?

Have you, or anyone living with you, worked on mines/industrial sites?

Are you aware of any other occupational hazards you might have been exposed to? (e.g. dental work/working at a dentist/asbestos exposure)

Do you use cosmetic creams/ make-up/ deodorant/ perfume/ hair products?

Section 5: General Dietary Habits

1. How would you describe your current eating pattern?
    - Regular meals/snacks
    - Skipping meals often
    - Eating irregularly or frequently eating out
    - Other (please describe)
2. How many meals do you typically eat in a day?
    - 1
    - 2
    - 3
    - 4+
    - Other (please describe)
3. Do you eat breakfast regularly?
    - Yes
    - No
    - Sometimes
4. How often do you consume the following? (Please circle frequency)
    - Fruits: Daily / Few times a week / Rarely / Never
    - Vegetables: Daily / Few times a week / Rarely / Never
    - Whole grains: Daily / Few times a week / Rarely / Never
    - Lean proteins (chicken, turkey, fish, tofu, legumes): Daily / Few times a week / Rarely / Never
    - Dairy (milk, cheese, yogurt): Daily / Few times a week / Rarely / Never
    - Processed foods (chips, packaged snacks, frozen meals): Daily / Few times a week / Rarely / Never
    - Sugary foods (candies, desserts): Daily / Few times a week / Rarely / Never
    - Take out: Daily/ Few times a week/ Rarely/ Never
5. Do you aim to eat mostly organic food?

6. Do you avoid pesticides where you can? (plastic food and drink containers, washing non-organic fruit and veg)

7. How much water do you typically drink daily?
    - Less than 1 cup
    - 1-2 cups
    - 3-4 cups
    - 5+ cups

8. Do you filter your drinking water?

9. Do you consume alcohol?
    - Yes, daily
    - Yes, occasionally
    - No

Section 6: Food Sensitivities & Preferences

1. Do you have any known food allergies or sensitivities? (Please list them)

2. Are you currently following any specific dietary regimen? (e.g., gluten-free, vegetarian, ketogenic, paleo, etc.)

3. Do you avoid any particular food groups or ingredients? If yes, why? (e.g., dairy, gluten, sugar, red meat, etc

4. How often do you eat out or order takeout?
    1. Rarely
    2. Once a week
    3. 2-3 times a week
    4. Almost daily

Section 7: Lifestyle Factors

1. Do you exercise regularly?
    - Yes
    - No
    - Occasionally
2. How many hours of sleep do you typically get each night?
    - Less than 5 hours
    - 5-6 hours
    - 7-8 hours
    - More than 8 hours
3. How would you rate your stress levels on a typical day?
    - Low
    - Moderate
    - High
4. Do you take any supplements or vitamins regularly? If so, please list them.

5. How often do you spend time in nature?

6. How often do you walk barefoot on the earth?

7. How often do you do things you enjoy? (massage/read/facials/hike etc)

Section 8: Health History

1. Do you have any of the following health conditions? (Check all that apply)
    - Digestive issues (e.g., bloating, constipation, acid reflux)
    - Chronic fatigue or low energy
    - Hormonal imbalances (e.g., thyroid issues, PMS, menopause)
    - Blood sugar imbalances (e.g., prediabetes, diabetes)
    - Cardiovascular disease
    - Autoimmune conditions
    - Mental health concerns (e.g., anxiety, depression)
    - Other (please specify)
2. Are you currently under the care of a healthcare professional?
    - Yes
    - No
3. Are there any other health concerns or symptoms you would like to share?

Section 9: Goals & Support

1. What are your primary health goals related to nutrition and diet? (e.g., weight loss, energy, digestive health, reducing inflammation)

2. How confident do you feel in making changes to your diet and lifestyle?
    - Very confident
    - Somewhat confident
    - Not confident at all
3. List concerns you may have in this regard:

4. What kind of support or resources would help you in improving your diet or overall health in general?