NUTRITIONAL THERAPISTS OF IRELAND

Mini Consultation Sheet

Name:

Email: **Phone:**

Health Goals / Health Concerns		Duration
1		
2		
3		

Do you experiernce any digestive problems such as bloating, constipation or heart burn

Please list all medication you are currently taking and the duration and/or regularity of consumption (remember to include the Pill, antacids, painkillers, antibiotics, inhalers):

Please list any supplements you are currently taking, brand name and the duration

How would you rate your health and wellbeing on a scale from 1-10 (10 being optimum)

How would you rate your energy on a scale from 1-10 (10 being optimum)

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Short term action Plan		Commencement
1		
2		
3		

Typical Day	Possible food swaps
Breakfast	**Breakfast**
Lunch	**Lunch**
Dinner	**Dinner**
Drinks and snacks	**Drinks and snacks**
Super foods for YOU:	