NELL MEAD

PHYSIOTHERAPIST

FOUNDATION QUESTIONNAIRE

Please answer these questions prior to your first session with Nell, and then bring these forms with you. This helps Nell to assess the state of your underlying tissue health, so that she can make pertinent recommendations for your treatment.

None of this information will be shared with anyone else, without your explicit consent, so please answer the questions honestly.

SLEEP

To assess your sleeping patterns, take psychologist Richard Wiseman's sleep test:

	Definitely yes	Yes	Uncertain	No	Definitely no
Do you need an alarm clock to wake you up in the morning?	5	4	3	2	1
Do you fall asleep within 5 minutes of going to bed?	5	4	3	2	1
Do you feel in control of your sleep? For example, can you fall asleep and wake up whenever you want?	1	2	3	4	5
During the day, do you often feel sleepy when you are, for example, driving, sitting in a meeting, or chatting?	5	4	3	2	1
Do you often feel like taking a nap during the day?	5	4	3	2	1

SCORE (therapist's use) _____

STRESS

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate by circling how often you felt or thought a certain way.

0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often

	Never	Almost never	Sometimes	Often	Very often
In the last month, how often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
In the last month, how often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
In the last month, how often have you felt nervous and "stressed"?	0	1	2	3	4
In the last month, how often have you felt confident about your ability to handle your personal problems?	4	3	2	1	0
In the last month, how often have you felt that things were going your way?	4	3	2	1	0
In the last month, how often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
In the last month, how often have you been able to control irritations in your life?	4	3	2	1	0
In the last month, how often have you felt that you were on top of things?	4	3	2	1	0
In the last month, how often have you been angered because of things that were outside of your control?	0	1	2	3	4
In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

SCORE (therapist's use) _____

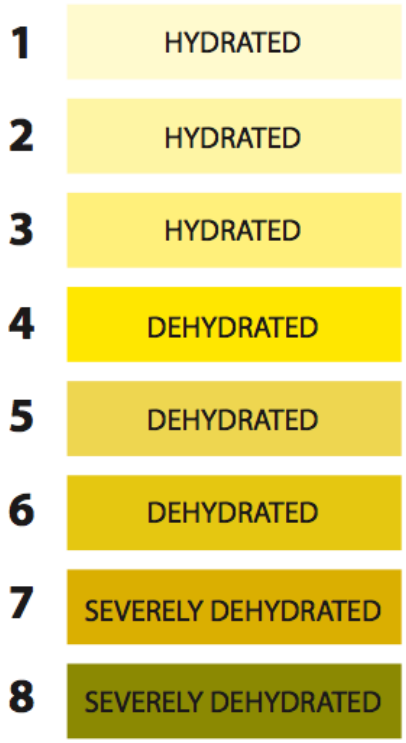
HYDRATION

Do you drink enough water..? Please answer the following questions.

	True	False
I drink at least 8 glasses of water per day.	0	1
I drink water before, during and after exercise EVERY TIME.	0	1
I rarely feel thirsty during the day.	0	1
I carry water with me throughout the day.	0	1
I drink little or no caffeine.	0	1
I often feel tired during the day.	1	0
I usually don't think about drinking water until I feel thirsty.	1	0
I tend to drink fizzy and caffeinated drinks most of the time.	1	0
I tend to have yellow to dark yellow urine most of the time.	1	0
I don't normally drink water until after exercising.	1	0

SCORE (therapist's use) _____

Urine colour chart:



Compare your urine colour to the eight- point colour scale. If you reach a score of 'dehydrated' or 'severely dehydrated' you should incorporate more water or more water-based food into your diet.

NUTRITION

Most of us like eating and are good at it! But – what do we eat, and do we get enough nutrients in our daily diet? Answer the following questions to find out where YOU stand.

	Yes	No
Do you have a good appetite?	0	1
Do you eat regularly?	0	1
Do you eat 3 full meals throughout the day?	0	1
Do you snack on healthy foods?	0	1
Do you stop eating when you feel full?	0	1
Do you stay away from sugary foods (cake, sweets, biscuits, chocolates, fruit juices, fizzy drinks, alcohol)?	0	1
Do you eat protein at every meal?	0	1
Do you eat 3 or more servings of dark fruits and vegetables a day?	0	1
Do you get omega 3 fats in your diet or take supplements for it?	0	1
Do you eat fibre-rich food every day?	0	1
Do you visit the loo once a day or more?	0	1
Is your weight stable?	0	1
Are most of your meals home-cooked?	0	1

SCORE (therapist's use) _____

Do you drink alcohol?	Never	Occasionally	Sometimes	Regularly	Too often
Do you smoke tobacco?	Never	Occasional puff	Weekly	Daily	>10 per day
Do you take street drugs?	Never	Occasionally	Monthly	Weekly	Daily
Do you take any prescribed medication?	Please list				