NUTRITION QUESTIONNAIRE

Name: _____ Date: _____
Address:
City: _____ State: _____ Zip: _____
Phone (home): Phone (work):_____
Date of Birth: _____Height:_____ Weight: _____
Email: _____
Reason for consultation and/or goals: _____
How many times do you usually eat per day? _____

Describe 3 full typical day's meals, snacks, and drinks, and time of each (please be specific and very complete):

Day 1: _____
_____

Day 2: _____
_____

Day3:_____
_____

HEALTH HISTORY

Occupation: _____
Marital Status: Single Partner Married Separated Divorced
Are you recovering from a cold or flu? _____ Are you pregnant? _____
Reason For office visit: _____
_____
Number of Children: _____
Date of last physical exam _____
Practitioner name and phone number_____
Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):
Outcome: _____
What types of therapy hove you tried for this problem(s):
Diet modification ( ) Fasting ( ) Vitamins/minerals ( ) Herbs ( ) Homeopathy ( )
Chiropractic ( ) Acupuncture ( ) Conventional drugs ( ) other ( )
List current health problems for which you are being treated:
_____
_____
Current medications (prescription or over-the counter):
_____
Major Hospitalizations, Surgeries, and Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____

_____ _____ _____

Circle the level of stress you ore experiencing on a scale of it 10 (1 being the lowest):
1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ( ) underweight ( ) overweight ( ) just right

Have you had an unintentional weight loss or gain of 10 pounds or more in the lost three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, and solvents) or health and/or life threatening activities (e.g., fireman, farmer, and miner)?
_____

Recent changes in your ability to: ( ) see ( ) taste ( ) smell
( ) feel hot/cold sensations ( ) move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the Following flavors: ( ) sour ( ) bitter ( ) sweet ( ) rich/fatty ( ) spicy/pungent ( ) salty

Strong dislike for any one of the following flavors: ( ) sour ( ) bitter ( ) sweet ( ) rich/fatty ( ) spicy/pungent ( ) salty

Do you: ( ) Prefer warmth (i.e., food, drinks, weather etc.) ( ) Prefer cold (i.e., food, drinks, weather, etc.) ( ) No preference
Is your sleep disturbed at the some time each night? _____ if yes, what time? _____

Time of day you feel the most energy or the least symptoms
( ) 7a.m.-9a.m. ( ) 9a.m.-lla.m. ( ) 11 a.m.-1 p.m.
( ) 1 p.m.-3p.m. ( ) 3p.m.-5p.m. ( ) 5p.m.-7p.m.
( ) 7p.m.-9p.m. ( ) 9p.m.-11 p.m. ( ) 11p.m.-1 a.m.
( ) 1 a.m.-3a.m. ( ) 3a.m.-5a.m. ( ) 5 a.m.-7a.m.

Time of day you feel the worst or your symptoms ore aggravated:
( ) 7a.m.-9a.m. ( ) 9a.m.-11a.m. ( ) 11 a.m.-1p.m.
( ) 1 p.m.-3p.m. ( ) 3p.m.-5p.m. ( ) 5p.m.-7p.m.
( ) 7p.m.-9p.m. ( ) 9p.m.-11 p.m. ( ) 11 p.m.-1a.m.
( ) 1 a.m.-3 a.m. ( ) 3 a.m.-5a.m. ( ) 5 a.m.-7 a.m.

Do you experience any of these general symptoms EVERY DAY?

( ) Debilitating fatigue
( ) Shortness of breath

( ) Insomnia
( ) Constipation
( ) Chronic pain/inflammation
( ) Depression
( ) Panic attacks
( ) Nausea
( ) Fecal incontinence
( ) Bleeding
( ) Disinterest in sex
( ) Headaches
( ) Vomiting
( ) Urinary incontinence
( ) Discharge
( ) Disinterest in eating
( ) Dizziness
( ) Diarrhea
( ) Low grade fever
( ) Itching/rash

Medical History:
( ) Arthritis
( ) Allergies/hayfever
( ) Asthma
( ) Alcoholism
( ) Alzheimer's disease
( ) Autoimmune disease
( ) Blood pressure problems
( ) Bronchitis
( ) Cancer
( ) Chronic fatigue syndrome
( ) Carpal tunnel syndrome
( ) Cholesterol, elevated
( ) Circulatory problems
( ) Colitis
( ) Dental problems
( ) Depression
( ) Diabetes
( ) Diverticular disease
( ) Drug addiction
( ) Eating disorder
( ) Epilepsy
( ) Emphysema
( ) Eyes, ears, nose, throat problems
( ) Environmental sensitivities
( ) Fibromyalgia
( ) Food intolerance
( ) Gastroesophageal reflux disease

( ) Genetic disorder
( ) Glaucoma
( ) Gout
( ) Heart disease
( ) Infection, chronic
( ) Inflammatory bowel disease
( ) Irritable bowel syndrome
( ) Kidney or bladder disease
( ) Learning disabilities
( ) Liver or gallbladder disease (stones)
( ) Mental illness
( ) Mental retardation
( ) Migraine headaches
( ) Neurological problems (Parkinson's, paralysis)
( ) Sinus problems
( ) Stroke
( ) Thyroid trouble
( ) Obesity
( ) Osteoporosis
( ) Pneumonia
( ) Sexually transmitted disease
( ) Seasonal affective disorder
( ) Skin problems
( ) Tuberculosis
( ) Ulcer
( ) Urinary tract infection
( ) Varicose veins
( ) Other:

Medical (men)
( )BHP
( )Prostate Cancer
( ) Decreased sex drive
( ) Infertility
( ) SID
( ) Other:

Medical (Women):
( ) Menstrual irregularities
( ) Endometriosis
( ) Infertility
( ) Fibrocystic breasts
( ) Fibroids/ovarian cysts
( ) Pelvic inflammatory disease
( ) PMS
( ) Breast cancer
( ) Vaginal infections
( ) Decreased sex drive
( ) STD

( ) Other
Age of first period _____
Date of last gynecological exam _____
Mammogram ( ) + ( ) –
PAP ( ) + ( ) –
Form of birth control _____
Of children _____
of pregnancies _____
( ) C-section _____
( ) Surgical menopause
( ) Menopause
Date of last menstrual cycle _____
Length of cycle _____ days_____
Interval of lime between cycles _____ days
Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty)?
_____

Family Health History:
(parents and siblings)
( ) Arthritis, rheumatoid
( ) Asthma
( ) Alcoholism
( ) Alzheimer's disease
( ) Cancer
( ) Depression
( ) Diabetes
( ) Drug addiction
( ) Eating disorder
( ) Genetic disorder
( ) Glaucoma
( ) Heart disease
( ) Infertility
( ) Learning disabilities
( ) Mental illness
( ) Mental retardation
( ) Migraine headaches
( ) Neurological disorders (Parkinson's, paralysis)
( ) Obesity
( ) Osteoporosis
( ) Stroke
( ) Suicide

Health Habits:
( ) Tobacco:
Cigarettes: #/day: _____
Cigars: #/day: _____
( ) Alcohol:
Wine: #glasses/day or wk _____
Liquor #ounces/day or wk_____

Beer: #glasses/day or wk _____
( ) Caffeine:
Coffee: #6 oz cups/day _____
Tea: #6 oz cups/day _____
Soda w/caffeine: #cans/day _____
Other sources _____
Water: #glasses/day_____

Exercise:
( ) 5-7 days per week
( ) 3-4 days per week
( ) 1-2 days per week
( ) 45 minutes or more duration per workout
( ) 30-45 minutes duration per workout
( ) Less than 30 minutes
( ) Walk
( ) Run, jog, jump rope
( ) Weight lift
( ) Swim
( ) Box
( ) Yoga

Nutrition & Diet:
( ) Mixed food diet (animal and vegetable sources)
( ) Vegetarian
( ) Vegan
( ) Salt restriction
( ) Fat restriction
( ) Starch/carbohydrate restriction
( ) The Zone Diet
( ) Total calorie restriction

Specific Food Restrictions:
( ) dairy
( ) wheat
( ) eggs
( ) soy
( ) corn
( ) all gluten
Other: _____

Food Frequency; Servings per day
Fruits (citrus, melons, etc.) _____
Dark green or deep yellow/orange vegetables_____
Grains (unprocessed) _____
Beans, peas, legumes _____
Dairy, eggs _____
Meat, poultry, fish_____

Eating Habits
( ) Skip breakfast
( ) Two meals/day
( ) One meal/day
( ) Graze (small frequent meals)
( ) Food rotation
( ) Eat constantly whether hungry or not
( ) Generally eat on the run
( ) Add salt to food

Current Supplements:
( ) Multivitamin/mineral
( ) Vitamin C
( ) Vitamin B
( ) EPA/DHA
( ) Evening Primrose/GLA
( ) Calcium, source _____
( ) Magnesium
( ) Zinc
( ) Minerals, describe _____
( ) Friendly flora (acidophilus)
( ) Digestive enzymes
( ) Amino acids
( ) Co-QIO
( ) Antioxidants (e.g., lutein, resveratrol), etc.)
( ) Herbs - teas
( ) Herbs – extracts
( ) Chinese herbs
( ) Ayurvedic herbs
( ) Homeopathy
( ) Bach flowers
( ) Protein shakes
( ) Super foods (e.g., bee pollen, phytonutrient blends)
( ) Liquid meals (e.g., Ensure)
( ) Other: _____

Would you like to:
( ) Have more energy
( ) Be stronger
( ) Have more endurance
( ) Increase your sex drive
( ) Be thinner
( ) Be more muscular
( ) Improve your complexion
( ) Have stronger nails
( ) Have healthier hair
( ) Be less moody
( ) Be less depressed
( ) Be less indecisive

( ) Feel more motivated
( ) Be more organized
( ) Think more clearly and be more focused
( ) Improve memory
( ) Do better on tests in school
( ) Not be dependent on over-the. counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
( ) Stop using laxatives or stool softeners
( ) Be free of pain
( ) Sleep better
( ) Have agreeable breath
( ) Have agreeable body odor
( ) Have stronger teeth
( ) Get less colds and flues
( ) Get rid of your allergies
( ) Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)