NUTRITION HEALTH QUESTIONNAIRE

Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All of your information is confidential.

Personal Identifying Information and Contact

Legal Name		
Age	Date of Birth (mm/dd/yyyy)	Sex and/or Gender Identity
Street Address		City, State, and Zip Code
Preferred Phone Number		May we leave a message here? Circle: YES or NO
Preferred Email Address		

Emergency Contact Information

Name	Relationship to You
Preferred Contact Information	

Medical Providers & Referral Information

Primary Care Physician or Referring Physician	Phone Number
Street Address	City, State, and Zip Code

Chief complaint(s); Tell us about any medical diagnoses you have received, why you are here for a nutrition consult and how long you've been experiencing these:

_____

_____

_____

_____

What other health care practitioners are you seeing?

_____

_____

Personal and Family History

Genetic Background (Check all that apply):

- ☐
- ☐ African American
- ☐ Asian
- ☐ Native American
- ☐ Mediterranean
- ☐ Caucasian
- ☐ Middle Eastern
- ☐ Other:

  _____
  _____
  _

Are you adopted? ☐Yes ☐No

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brother(s)		
Sister(s)		
Children		

Medications and Supplements: Please list all **prescription medications** and **nutritional supplements, herbs** you are currently taking. Use a separate sheet if needed.

Name	Dosage	Frequency	Length of time	Purpose

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, Tylenol, antibiotics, etc)?

List major traumas, major or minor surgeries, and hospitalizations?

_____

_____

_____

Physical Activity and Lifestyle

Are you satisfied with your energy level? _____

Are there any problems/limitations that inhibit your physical activity? _____

Activity	Type(s)	Days per week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

What do you do for relaxation?

_____

How many hours of sleep do you get a night/day?

_____

Do you sleep through the night? _____ Do you feel rested upon waking?

_____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:

Work: _____ Current health status: _____ Social/family situation: _____ Life in general: _____

What do you believe you can do to make a difference in your current health? _____

_____

_____

Environmental information:

How often are you exposed to any of the following? Insert a number and check day or week.

Cigarette smoke: _____ x □day / □week	How many mercury fillings do you have? _____
Wood stove: : _____ x □day / □week	Recreational drugs: _____ x □day / □week
Perfumes/hair dyes: _____ x □day / □week	Pet dander: _____ x □day / □week
Car exhaust: _____ x □day / □week	Mold: _____ x □day / □week
Pesticides: _____ x □day / □week	Cleaning products: _____ x □day / □week
Dry cleaned clothes: _____ x □day / □week	Teflon or aluminum pans: _____ x □day / □week

Bottled water: _____ x □day / □week	Photo developing/harsh chemicals: _____ x □day / □week

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Nutrition:

Have you ever had a nutritional consultation?

_____

Please list food allergies/intolerances/sensitivities and the reaction you experience when eating these foods:

_____

_____

_____

Please list non-food and environmental allergies:

_____

Please list any special dietary restrictions/habits you have:

_____

What foods do you crave if anything?

_____

What are your favorite foods?

_____

Where do you grocery shop?

_____

Please describe any changes you have made to your diet to improve your health? _____

_____

_____

How would you describe your relationship to food?

_____

Height: _____ Weight: _____ Ideal Weight: _____

Highest Adult weight: _____ Year: _____

Lowest Adult Weight: _____ Year: _____

Symptom Review: Please check or write “C” for symptoms noticed in the past year. Any major problems that you had previously, but no longer have, mark with a “P”. Mark the space to the right of the symptom.

Body Systems 1			
Indigestion, burping, bloating or sleepy immediately after meals		Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma		Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)		Loss of taste for meat	
Sense of excess fullness after meals		Feel like skipping breakfast, overall low appetite	
Undigested food in stool		Anemia, unresponsive to iron	

Body Systems 2			
Heartburn or acid reflux symptoms		Nausea in mornings	
Strong appetite, demanding hunger, excess salivation		Aggravated by spice or sour, sour burps, sour smell	

Body Systems 3			
Pain between shoulder blades		Stomach upset by fatty or friend foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools		Nausea	
Light, clay colored or greenish/yellow stools		Dry skin, itchy feet or skin peels on foot	
Gallbladder attacks		Gallbladder removed	
Body Systems 3, Continued			
Bitter taste in mouth, especially after meals		Easily intoxicated or hung over if you were to drink wine	
Pain under right side of rib cage		Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke			

Body Systems 4			
Food allergies or sensitivities (wheat or grain, or dairy or other)		Frequent intake of allergenic food(s), strong attachment to allergenic foods	
Craving, addiction, or binging on allergenic food(s)		Abdominal bloating 1 - 2 hours after eating	
Pulse speeds up after eating		Pulse speeds up after eating	
Crohn's disease, frequent sinus infection, migraines, asthma		Airborne allergies	
Experience hives			

Body Systems 5			
Catch colds at the beginning of winter		Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Experienced a mucous producing cough		Never sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic conditions		Have food allergies or sensitivities	

Body Systems 6			
Coating on your tongue		Anus itches	
Fungus or yeast infections		Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day		Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas		Irritable bowel or mucous colitis	
Bad breath of strong body odor		Cramping in lower abdominal region	
Stools are difficult to pass		History of parasites	
Stools have corners or edges, are flat ribbon shaped			

Body Systems 7			
Eat less than five servings of (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day		Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon		Sleepy in the afternoon	
Fatigue is relieved by eating		Binging or uncontrolled eating	
Excessive appetite		When you eat snacks/sweets, do you eat them, get a temporary boos of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are			

skipped or delayed			
Heart palpitations after eating sweets		Have frequent thirst	
Have frequent urination		Once you start eating sweets or carbohydrates, do you feel you can't stop?	
Tend to gain weigh in the belly		Have pre-diabetes, PCOS, hypoglycemia or alcoholism or a family history of any of these	
Have elevated triglycerides or cholesterol		Have high blood pressure	

Body Systems 8			
Have high or low blood pressure		Have a low libido	
Have trouble falling asleep		Get less than 8 hours of sleep a night	
Go to bed frequently after midnight		Get less than 1 hour a day of sunlight	
Work the night shift		Are you an emotional eater?	
Feel anxious or have panic attacks		Are you a shallow breather?	
Experience heart palpitations		Cravings for salt or sweets	
Experience chronic or prolonged fatigue		Does fatigue prevent you from doing things you would like to do? Interfere with work, family or social life?	
Do you feel you can't get started in the morning without coffee or caffeinated drinks?			

Body Systems 9			
Are you cold when everyone else is warm?		Have coarse or brittle hair	
Experience constipation		Have thinning hair or hair loss	
Experienced a loss of sex drive		Lost the outside of your eyebrow	
Experience depression		Have trouble losing weight	
Have low blood pressure or heart rate		Have elevated cholesterol	
Have a hoarse voice		Have dry, scaly skin	
Have cold hands and feet		Experience fatigue	
Experience fluid retention			

Body Systems 10			
Aware of irregular or heavy breathing		Experienced discomfort at high altitudes	
Sigh frequently or "air hunger"		Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at the end of day		Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiate into left arm, worse on exertion		Have muscle cramps on exertion	

Body Systems 11			
Rarely break out into a sweat		Use aluminum cooking equipment	
Have mercury amalgams		Heat food in plastic containers in microwave	
Have your clothes dry-cleaned		Eat "fast food" more than 2x a week	
Drink tap, well or bottled water		Have strong body odor	
Have acne on face or buttocks		Drink less than 4 cups of water a day (approx. 30 oz.)	
Live in a large urban or industrial area		Use lawn or garden chemicals	
Have less than one bowel movement per day		React to small amounts of alcohol	
Sit on your computer 3+ hours a day		Exercise less than 3 times a week	
Use tobacco products		Eat large fish (sword fish, tuna, shark, tilefish) more than once a week	
Urinate small amounts of dark urine only a few times daily		Frequently exposed to solvents and chemicals at work or home	

Feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine		Have a negative reaction when you consume foods containing MSG, sulfites or other preservatives	