Third Space Wellness, LLC

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		Preferred 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? Check: ☐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

What do you hope to achieve during your visit with a nutritionist?

What are your top three health/nutrition concerns or symptoms?

1.
2.
3.

Family History Please list any family history of the following: heart disease, high blood pressure, stroke, overweight, diabetes, cancer, lung disease, kidney disease, mental illness, addiction, etc.**:**

Medical History: Please note health conditions you have currently "C" or in the past "P."

__ Acne
__ Addiction ________________
__ ADD/ADHD/Executive Function Disorder
__ Allergies: Enviro ________________
__ Allergies: Seasonal ________________
__ Anxiety
__ Arthritis
__ Asthma
__ Autoimmune Condition: _____________
Blood Sugar:
__ Pre-Diabetes
__ Diabetes Type 1or __ Diabetes Type 2
__ Hypoglycemia
__ Cancer: Type ________________
__ Celiac Disease
__ Chronic Fatigue Syndrome/SEID
__ Depression
__ Eating Disorder: ________________
__ Eczema
__ Fertility Concerns
__ Menopause
__ Menstrual Concerns
__ Polycystic Ovarian Syndrome (PCOS)
__ PMS
__ Fibromyalgia
__ GI Condition: ________________

__ GERD/Heartburn
__ Hiatal Hernia
__ Peptic Ulcer
IBD: __ Crohn's __ Ulcerative Colitis
__ IBS: Type ________________
__ Gout
__ Headaches or __ Migraines
__ Heart Condition: ________________
__ High Blood Pressure /Hypertension
__ High Cholesterol
__ Hyperthyroid
__ Hypothyroid
__ Kidney Stones
__ Memory Concerns
__ Neurological Disease: _______________
__ Obesity __ Overweight
__ Osteopenia __ Osteoporosis
__ Osteoarthritis
__ Physical Limitation: ________________
__ Psoriasis
__ Prostate
__ Sexual Dysfunction
__ Sleep Apnea
__ Urinary Tract Infections
Other/Comments: ________________

Pertinent Lab & Diagnostic Data (can be provided as a separate document):

____

____

Trauma, Surgeries & Hospitalizations:

____

____

Height: _______ **Weight:** _______ **Ideal Weight:** _______

Highest Adult Weight & Year: _______ **Lowest Adult Weight & Year:** _______

Digestive Function: ☐Good ☐Fair ☐Poor
Bowel Movements: ☐Daily ☐<1x day ☐1-2x day

Please indicate how often you experience the following symptoms:

Heartburn	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Belching	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Gas/Flatulence	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Bloating	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Stomach Pain	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Nausea/Vomiting	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely

Diarrhea	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely
Constipation	☐ Frequently	☐ Often	☐ Occasionally	☐ No/Rarely

Have you had prolonged or regular use of NSAIDs? (Advil, Aleve, Motrin, Aspirin)

Have you had prolonged or regular use of Tylenol?

Have you had prolonged or regular use of PPIs or acid blocking drugs?

How often do you take antibiotics? >3 times per year? Frequent antibiotics use in childhood?

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

Do you follow a particular diet/eating pattern or have any dietary restrictions?

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

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

Eating Style: Based on how you eat on a regular basis, please check all that apply:

- ☐ Fast Eater
- ☐ Family member(s) have different tastes
- ☐ Erratic eater
- ☐ Love to eat
- ☐ Emotional eater (stressed, bored, sad, etc.)
- ☐ Eat too much
- ☐ Late night-eater
- ☐ Eat because I have to
- ☐ Time constraints
- ☐ Negative relationship with food
- ☐ Dislike “healthy” food
- ☐ Struggle with eating issues
- ☐ Travel frequently
- ☐ Confused about food/ nutrition
- ☐ Do not plan meals/ menus
- ☐ Frequently eat fast food
- ☐ Rely on convenience items
- ☐ Poor snack choices