**Nutritional Questionnaire for Adults**

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges. **To enhance your scheduled consult time, please have this back to me at least 1 day prior to your appointment, if possible. Please email it to\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

Name:       Today’s date:

Address:       City:       State:       Zip:

E-mail Address:       Fax Number: (   )    -

Home Phone: (   )    -     Work: (   )    -     Cell: (   )    -

Birthdate:       Age:       Place of Birth:

Occupation:       Referred By:       Blood Type:

Height:       Weight:       Sex:       Desired Weight:       Last Age at Desired Weight:

Highest Adult Weight:       What Age?:       Lowest Adult Weight:       What Age?:

Have you ever dieted?:  Yes  No If Yes, how many times in your adult life?

Which diet(s) worked:

1. Please check appropriate box:

|  |  |  |  |
| --- | --- | --- | --- |
| African American | Hispanic | Mediterranean | Asian |
| Native American | Caucasian | Northern European | Other |

2. Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

|  |  |  |  |
| --- | --- | --- | --- |
| DESCRIBE PROBLEM | MILD/ MODERATE/ SEVERE | TREATMENT APPROACH | SUCCESS |
| **Example:** Post Nasal Drip | Moderate | Elimination Diet | Moderate |
| a. |  |  |  |
| b. |  |  |  |
| c. |  |  |  |
| d. |  |  |  |

**3. PAST MEDICAL AND SURGICAL HISTORY:**

|  |  |  |
| --- | --- | --- |
| 3. **ILLNESSES** | **WHEN** | **COMMENTS** |
| a. Anemia (type) |  |  |
| b. Arthritis |  |  |
| c. Asthma |  |  |
| d. Bronchitis |  |  |
| e. Cancer |  |  |
| f. Chronic Fatigue Syndrome |  |  |
| g. Crohn's Disease or Ulcerative Colitis |  |  |
| h. Diabetes |  |  |
| i. Emphysema |  |  |
| j. Epilepsy, Convulsions or Seizures |  |  |
| k. Gallstones |  |  |
| l. Gout |  |  |
| m. Heart Attack/Angina |  |  |
| n. Heart Failure |  |  |
| o. Hepatitis |  |  |
| p. High Blood Fats (cholesterol, triglycerides) |  |  |
| q. High Blood Pressure (hypertension) |  |  |
| r. Irritable Bowel |  |  |
| s. Kidney stones |  |  |
| t. Mononucleosis |  |  |
| u. Pneumonia |  |  |
| v. Sinusitis |  |  |
| w. Sleep Apnea |  |  |
| x. Stroke |  |  |
| y. Thyroid disease |  |  |
| z. Other (describe) |  |  |
| **INJURIES** |  |  |
| ab. Back injury |  |  |
| ac. Broken Bones |  |  |
| ad. Head Injury |  |  |
| ae. Neck Injury |  |  |
| af. Other (acute) ex: sprained muscle |  |  |
| ag. Other (chronic) ex: bad knees |  |  |
| **DIAGNOSTIC STUDIES** |  |  |
| ai . Bone Scan |  |  |
| aj. CAT Scan |  |  |
| ak. EKG |  |  |
| al. MRI |  |  |
| am. Upper/Lower GI Series |  |  |
| an. Other (describe) |  |  |
| **OPERATIONS** |  |  |
| ao. Dental Surgery |  |  |
| ap. Gallbladder |  |  |
| aq. Hysterectomy |  |  |
| ar. Tonsillectomy |  |  |
| as. Other (describe) |  |  |

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)

Maternal side:

Paternal side:

5. Are your parents living?  No  Yes

If no, comment:

6. Did you have any health issues as a child?  No  Yes - What age?

Describe:

7. As a **child,** where there foods you avoided?  No  Yes-(please specify below)

|  |  |
| --- | --- |
| **Food** | **Symptoms** |
| Ex: Milk | Ex: Gas and diarrhea |
|  |  |
|  |  |
|  |  |

8. Please mark in the chart below with information about recent bowel movements:

|  |  |  |  |
| --- | --- | --- | --- |
| **Frequency:** |  | **Color:** |  |
| More than 3 times a day |  | Dark brown |  |
| 2-3 times a day |  | Medium brown |  |
| One time per day |  | Very dark or black |  |
| 4-6 times a week |  | Greenish |  |
| 2-3 times a week |  | Blood is visible |  |
| Once or fewer a week |  | Varies a lot |  |
| **Consistency:** |  | Yellow, light brown |  |
| Soft and well formed |  | Greasy, shiny appearance |  |
| Often float |  |  | |
| Difficult to pass |  |
| Diarrhea |  |
| Thin, long or narrow |  |
| Small and hard |  |
| Loose, but not watery |  |
| Alternating between hard and loose/watery |  |

9. Do you experience intestinal gas? (check all that apply)

present with pain  foul smell  little odor  excessive daily  occasionally

10. Do you experience anal itching?  frequently  occasionally  rarely  never

11. Do you experience any heartburn, chest pressure, or stomach pain?  No  Yes

If yes, do you take anything for relief? (list):

**WOMEN ONLY: (Questions 12-21)**

12. Have you ever been pregnant?  No  Yes

If yes, please answer the following:

a. Number of miscarriages:       b. Number of abortions:       c. Number of preemies:

d. Number of term births:       e. Birth weight of largest baby:       Smallest baby:

f. Did you develop toxemia?  No  Yes

g. Have you had any other problems with pregnancy?  No  Yes

If yes, describe:

13. Age of first mensus:

14. Date of last Pap Smear:       Normal  Abnormal

15. Date of last Mammogram:       Normal  Abnormal

16. Do you currently use contraception?  No  Yes-(type?)

17. Are you currently taking birth control pills?  No  Yes-(how long?)

If you’re on the pill please comment on physical or mental changes from before taking to now:

18. Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)?

No  Yes-(specify)

19. Have you ever experienced PMS in the past?  No  Yes – When?:

20. Are you still menstruating?  Yes  No - (age of last period):

21. Are you experiencing menopause symptoms?  No  Yes

22. Do you take:  Estrogen  Estrace  Premarin  Other-(specify):

23. **(Men and Women)** Do you have urinary problems?  No  Yes

If yes, please specify:  Nightly urination  Frequent day time urination  Hesitancy

Irregular  Dribbling afterwards  Frequent urge to urinate  Difficulty

Feeling of incomplete emptying  Burning sensation

24. **(Men Only):** Do you have prostate swelling?  No  Yes

**DENTAL, etc.:**

25. Do you have amalgam (silver, black or grey) fillings?  No  Yes (how many?):

26. Have you ever had fillings replaced?

No  Yes-(how many?       when?       with what material?      )

27. Do you have root canals?  No  Yes (how many?      ) Any Problems?

28. Have you had any cavities in the last 2 years?  No  Yes (how many?      )

29. Do your gums ever bleed?  No  Yes-(how often?      )

30. Do you ever grind your teeth?  No  Yes

31. Do you have any artificial joints or implants anywhere in the body or mouth?  No  Yes

**SOCIAL:**

32. How well have things been going for you lately?:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Great** | **Good** | **Could be better** | **Not very good** | **Does Not Apply** |
| a. school |  |  |  |  |  |
| b. job |  |  |  |  |  |
| c. social life |  |  |  |  |  |
| d. close friends |  |  |  |  |  |
| e. sex |  |  |  |  |  |
| f. your attitude |  |  |  |  |  |
| g. boy/girlfriend |  |  |  |  |  |
| h. children |  |  |  |  |  |
| i. parents |  |  |  |  |  |
| j. spouse |  |  |  |  |  |

33. With whom do you live? List age of children, if any.

34. What is the attitude of those close to you concerning your health?

Supportive  Not supportive  Indifferent

35. Are you currently married, or have you ever been married?  No  Yes

If yes, when:       If yes, spouseʼs occupation:

Have you been separated or divorced?  No  Yes - If yes, when?:

36. What are your hobbies and leisure activities?

37. Describe previous jobs/work:

38. Have you lived outside of the United States?  No  Yes If yes, where/when?

39. What is your total amount of airline trips, in the last year?

Estimated total in life:       How many out of the country:

40. Have **you** experienced any major losses in your life?  No  Yes

If so, please comment:

41. Have you or your **family** recently experienced any major life changes (such as a job change)?  No  Yes

If yes, please comment:

42. Have you ever had psychotherapy or counseling?  No  Yes

If yes, what kind?       when?

Additional comments:

**LIFESTYLE:**

43. How important is religion (or spirituality) to you?

Not at all important  Somewhat important  Extremely important

44. Do you meditate?  occasionally  often  never

45. How much control do you feel you have over your current state of health? Rate 1-10 (none-all)

Comment:

46. How much time have you lost from work or school in the past year due to illness?

0-2 days  3-5 days  6-14 days  more

47. What is your usual bed time?       wake time?

48. How well do you sleep? (check all that apply)

Adequate-(sleep through the night)  Wake up feeling well rested

Trouble falling asleep  Wake up still tired

Trouble staying asleep-(How many times do you wake during the night?      )

49. Check off typical bedtime activities:

Watch television  Read a book  Listen to music  Bed time snack

Meditate  Bathe/shower  Drink alcohol  Drink caffeinated beverage

Other-(specify):

50. Do you ever need to take a sleep aid?  No  Yes – Which ones at what dose?

How often:

51. Do you exercise regularly now?  No  Yes-(specify): Have you in the past?  No  Yes

Once per week  2 times per week  3 times per week  4 times per week or more

Amount per session:  less than 15 minutes  15-30 minutes  30-45 minutes  > 45 minutes

Other-(specify):

52. What type of exercises do you do currently (dog walking does not count)?

Jogging  Walking  Weight training  Water sports  Aerobics  Yoga

Other-(specify):

53. Do you get sun exposure?  No  Yes-(specify) :  Daily  Weekly How much?

54. Do you wear sun block?  No  Yes-(percentage of time      )

**ALLERGY & TOXIC POTENTIAL:**

55. Do you have any pets or farm animals?  No  Yes - List:

If yes, where do they live?  Indoors  Outdoors  Both

56. Do odors such as perfume, cleaning solutions, smoke, etc. affect you?  No  Yes

If yes, explain:

57. Have you, to your knowledge, been exposed to toxic metals at your job or at home?

No  Yes:  Lead  Cadmium  Arsenic  Mercury  Aluminum

Explain:

58. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?

No  Solvents  Paints  Pesticides  Petrochemicals

Coal  Hydrocarbons  Mold  Other (specify):

59. Do you now or have you recently lived in an older home (pre 1970ʼs)?:  No  Yes

If yes, how old is/was home?       How long have/did you live there?

60. Have you ever lived or worked in a water damaged building?  No  Yes

If yes, when?       How long?

61. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes?

No  Yes-(explain):

How often do you wear dry cleaned clothing?

62. Do you have a regular lawn care service?  No  Yes-(how often?      )

63. Do you regularly spray for pests outdoors?  No  Yes-(how often?      )

64. Do you use bug spray (outside) or insecticides (indoors) on a regular basis?  No  Yes

65. How often are you exposed to burning coal, bonfires, fire pits, etc.?

66. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| No | Yes- Currently:  1-3 drinks per week | 4-6 | 7-10 | 10 or more |
|  | Yes- In the past:  1-3 drinks per week | 4-6 | 7-10 | 10 or more |

If you have quit, when?

67. Have you ever used tobacco?  No  Yes-(specify:      ) If yes, number of years:

Amount per day:       Year quit?

68. Are you now or were you ever regularly exposed to second hand smoke?  No  Yes When?

69. Have you ever used recreational drugs?  No  Yes-(specify:      )

**MEDICATIONS:**

70. What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

|  |  |  |  |
| --- | --- | --- | --- |
| **Medication Name** | **Purpose** | **Dosage** | **Start Date** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |

71. Do you take any other over the counter medications on an **occasional basis**?

If yes, which one(s)?

72. How many times have you taken antibiotics as an infant or child?

Less than 5 times  More than 5 times  More than 10 time  So many times I lost count

Reason:

73. As an adult, how often do you take antibiotics?

Never  Once a year (on average)  1-3 times a year (on average)

Longer-(explain):

Why?

74. Were you ever on antibiotics for a prolonged period of time?  No  Yes

If yes, explain:

75. Fill in the chart below for how many times you have taken oral steroids (e.g. Cortisone, Prednisone, etc.):

Less than 5 times Greater than 5 times Greater than 10 times

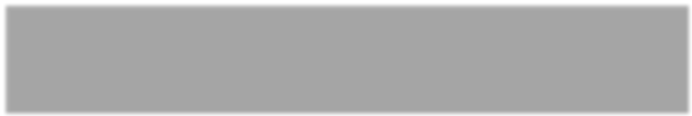
|  |  |  |  |
| --- | --- | --- | --- |
| Infancy/Childhood |  |  |  |
| Teen |  |  |  |
| Adulthood |  |  |  |

76. List all vitamins, minerals, and other nutritional supplements that you are currently taking. Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

|  |  |  |  |
| --- | --- | --- | --- |
| **Vitamin/Herbal Supplement(s)** | **Brand** | **How Many and When?** | **Start Date** |
| 1. |  |  |  |
| 2. |  |  |  |
| 3. |  |  |  |
| 4. |  |  |  |
| 5. |  |  |  |
| 6. |  |  |  |
| 7. |  |  |  |
| 8. |  |  |  |
| 9. |  |  |  |
| 10. |  |  |  |
| 11. |  |  |  |
| 12. |  |  |  |
| 13. |  |  |  |
| 14. |  |  |  |

**\*\*If you’re being seen in person, please bring**

**bottles with you to your appointment\*\***



**DIETARY HABITS:**

77. Are you currently on a special diet (i.e., vegetarian, South Beach, etc)?  No  Yes

If yes, how long and describe:

78. Usual Breakfast time:       Lunch time:       Dinner time:

Snack time:       Snack time:       Snack time:

79. Place a mark next to the food/drink that applies to a typical day of your current diet.

|  |  |  |  |
| --- | --- | --- | --- |
| **Usual Breakfast** | **Usual Lunch** | **Usual Dinner** | **Usual Snacks** |
| None | None | None | None |
| Cereal | Eat in cafeteria | Pasta | Nuts |
| Wheat Bran | Eat in restaurant | Potato | Fruit |
| Oatmeal | Leftovers | Brown rice | Vegetables |
| Toast | Meat sandwich | White rice | Pretzels |
| Bagel | Fish sandwich | Beans (legumes) | Potato Chips |
| Sweet roll | Lettuce (on sandwich) | Fish | Corn Chips |
| Donut | Tomato | Red Meat | Crackers |
| Eggs | Salad | Poultry | Cheese |
| Bacon/Sausage | Salad dressing | Salad | Cookies |
| Fruit | Soup | Salad dressing | Cake/Pastries |
| Yogurt | Fruit | Green vegetables | Nut butters |
| Milk | Yogurt | Carrots | Cereal |
| Juice | Milk | Yellow vegetables | Ice cream |
| Tea | Juice | Milk | Trail mix |
| Coffee | Tea | Juice | Dried fruit |
| Water | Coffee | Tea | Other: (list) |
| Butter | Water | Coffee |  |
| Margarine | Regular soda | Water |  |
| Sugar | Diet soda | Regular soda |  |
| Sweetener | Butter | Diet soda |  |
| Leftovers | Margarine | Butter |  |
| Other: | Mayonnaise | Margarine |  |
|  | Sugar | Sugar |  |
|  | Sweetener | Sweetener |  |
|  | Other: | Other: |  |
|  |  |  |  |

80. Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.?  No  Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea)

81. Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*

No  Yes

If yes, specify:

82. How much of the following do you consume on average?

**Food Amount Per Day Amount Per Week**

|  |  |  |
| --- | --- | --- |
| Candy |  |  |
| Cheese |  |  |
| Chocolate |  |  |
| Cups of caffeinated coffee |  |  |
| Cups of decaffeinated coffee |  |  |
| Cups of hot chocolate |  |  |
| Cups of tea (containing caffeine) |  |  |
| Diet sodas (cans) |  |  |
| Regular soda (cans) |  |  |
| Ice cream |  |  |
| Salty snacks |  |  |
| Slices white bread/rolls/1/2 bagel |  |  |
| Nuts |  |  |

83. Do you feel **much worse** when you eat any of the following: (check all that apply)

high fat foods  refined sugar (junk foods)  high protein foods  fried foods

high carbohydrate foods  1 or 2 alcoholic drinks

(breads, pastas, potatoes)  Other (specify):

84. Do you feel **much bette**r when you eat a lot of: (check all that apply)

high fat foods  refined sugar (junk foods)  high protein foods  fried foods

high carbohydrate foods  1 or 2 alcoholic drinks

(breads, pastas, potatoes)  Other (specify):

85. Do you feel **worse** at certain times of the year?  No  Yes-(when?      )

How do you feel?

86. Do you feel **better** at certain times of the year?  No  Yes-(when?      )

How do you feel?

87. Does skipping a meal affect you in any way?  No  Yes – Explain:

88. Do you ever crave or “binge” on certain foods?  No  Yes

Which foods, how often and comment on possible stressors/triggers?

89. Do you avoid certain foods for any reason?  No  Yes

Which foods and why?

**Food Frequency List**

Please indicate the  **approximate number of times** you have eaten these foods in a typical week. For each section you may **check or list** thefoods/beverages that you DO eat, and **leave blank** thefoods/beverages seldom consumed.

|  |  |  |  |
| --- | --- | --- | --- |
| **Consumed in the past 7 days** | Number of Times | **Consumed in the past 7 days** | Number of Times |
| **Vegetables:**  **Dark green leafy:** spinach,  Romaine,  leaf lettuce,  Caesar Salad, etc. |  | **Fish: (list):**  Is it:  fresh,  fried,  canned |  |
| **Iceberg lettuce** or **bagged salad combos**,  celery,  cucumbers,  zucchini |  | **Poultry: Chicken:** dark meat,  breast  **Turkey:** dark meat,breast,lunch meat,turkey bacon bacon |  |
| **Broccoli**,  Brussels sprouts,  cabbage/coleslaw,  kale,  turnip or mustard greens |  | **Beef:** hamburgers, steak, meatloaf, stew, chili  Is it usually:  regular,  lean,  grass-fed, or  organic |  |
| Fresh/frozen **mixed** veggies:  corn,  green beans,  peas |  | **Pork:** ham,  sausage,  bacon |  |
| **Yellow-orange veg**:  carrots,  squash,  sweet potatoes |  | **Hot dogs:** beef or turkey,  bratwurst,  Italian sausage, etc. |  |
| **Tomatoes**,  pasta sauce,  tomato juice,  V-8,  salsa, etc |  | **Fried foods:** fries,  chicken, etc. |  |
| **Fresh vegetable juices (list):** |  | **Lunchables**®**,**  **bologna,**  **salami,** etc. |  |
| **Other (list):** **ORGANIC?** |  | **Vegetarian foods (list):** |  |
|  |  | **Indian Vegetarian foods (list):** |  |
| **Fruits:** banana, pear, apple, grapes, kiwi  **Other:** |  | **Beans, legumes, peas:** bean/lentil soup,  bean burritos,  veg chili,  split pea soup, etc. |  |
| **Berries (list):** |  | Vegetarian foods (list): |  |
| **Canned/jar fruit:** applesauce,  pears,  peaches |  | **Veggie burgers,** **TVP,** **tofu,** **tempeh,** **seitan,** **Quorn**® **products, etc.** |  |
| **Dried fruits (list):** |  | **Raw nuts/seeds:** almonds,  sunflower seeds,  pecans,  walnuts, etc. |  |
|  |
| **Wheat bread:** rolls,  buns,  sandwiches, pita, bagel,  White,  whole grain,  low carb,  spelt,  Ezekiel® |  | **Trail mix**,  roasted salted nuts |  |
| **Cold cereal (list):** |  | **Peanuts**, peanut butter, **almond** butter, tahini, etc |  |
| **Hot cereal (list):** |  | **Protein** powders:  **soy,**  **whey,**  **egg or**  **rice?** |  |
| **Pancakes**,  waffles  T**ortillas:** corn,  flour |  | **Protein:** liquid (ready-to-drink) |  |
| **Muffins**,  donuts,  sweet rolls,  granola bars |  | **Flax** seed meal or flax oil,  **cod liver oil**? |  |
| **Pretzels**,  crackers, etc. |  | **Butter:** **ORGANIC?** |  |
| **Gluten-free foods (list):** |  | **Margarine (list brand):** |  |
| **Rice:** white,  brown,  long-grain or wild,  fried |  | **Potato chips**,  Fritos®,  Doritos®, Pringles®, etc. |  |
| **Potatoes: What kind?** **Prepared?** |  | **Popcorn:**  **pre-packaged or**  **homemade** |  |
| **Pasta:** spaghetti,  lasagna,  macaroni,  pasta salad, etc. |  | **Candy (list):** |  |
|  |  | **Pie, cake, cookies, other snacks (list):** |  |
| **Eggs:**  whole,  whites only |  | **Gum**, breath mints:  regular,  sugar-free |  |
| **Dairy:** Cow's milk: **what kind?**  **ORGANIC?** |  | **Coffee/espresso drink?**  regular or  decaf  # of 8oz cups? |  |
| **Yogurt,**  **cheese**,  nachos,  cottage cheese  **ORGANIC?** |  | **Tea:** black, green, white, herbal infusion |  |
| **Pizza:** sausage,  pepperoni,  vegetable, etc. |  | **Sugar or no/low calorie sweetener? (list):** |  |
| **Ice cream,**  **frozen yogurt**,  shakes/malts, etc. |  | **Soda pop:** **regular or** **diet?** **(list):** |  |
| **Soy milk**, **goat** milk, **rice** milk, **almond** milk |  | **Alcohol** beverage:  wine,  beer,  hard liquor |  |
| **Check other frequent foods:** Frozen/microwave meals:  Weight Watchers®,  Lean Cuisine®,  Healthy Choice®,  Mexican cuisine,  Indian cuisine,  Chinese/Thai,  Vegetarian,  Atkins®,  Low carb,  SlimFast®, etc. | | | |
| **Average daily water intake in 8 oz glasses (not counting soda pop or coffee):** 1-2 3-4 5-6 7-8 9-10  Is it:  **tap water,**  **filtered tap water,**  **spring water,**  **distilled, etc.? If filtered, how?** | | | |

90. How many times a week do you eat out?

Rate the type of restaurants you frequently eat at in order of most to least often (1 being the kind you eat at most often, and 5 for the least often or never):

Fast food fine dining café coffee shop or Corner bakery type place

Casual dining breakfast dinner grocery store deli health food store deli

91. Are you the primary cook for the household? . If not, who is?

92. On a scale of 1-5, rate what extend you enjoy preparing/cooking food (1 – a lot, 5 – hate it!)

93. Where do you do the bulk of your grocery shopping?

94: What percentage of your food intake is Organic?

95: Do you drink bottled water? . If yes, appox how many bottles per day?

What size?

**Anything else you think we should know? This is the place where you can detail your main concerns and what you expect to get out of working with me:**