

NUTRITION QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ Phone

(work): _____

Date of Birth: _____ Height: _____ Weight: _____

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: _____

Day 3: _____

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Do you smoke? _____ Drink alcohol? _____ How much/when? _____
Do you drink caffeine every morning? _____

Do you ever overeat? _____ If so, which foods and how often? _____

Do you have any food allergies, restrictions, or sensitivities? _____

Describe your daily energy levels: _____

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a while? _____

Do you crave any of the following?

- | | | |
|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Meat | <input type="checkbox"/> Fat |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Desserts | <input type="checkbox"/> Milk | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bread | <input type="checkbox"/> Fried Foods | _____ |

Do you take any nutritional supplements or vitamins? _____ If so, which ones? (be specific. Attach sheet if necessary) _____

Which prescription and over the counter medications do you take regularly?

Which oils do you use/consume?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Soybean Oil | |

How is your dental health? _____

How often do you have bowel movements? _____

Urinate? _____

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Rank your skin without lotion:

- Very Dry
- Dry
- Normal
- Oily
- Combination

Please check off any of the following that pertain to you (past or present):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty <i>losing</i> weight | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Difficulty <i>gaining</i> weight | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emotional problems (instability or sensitivity) | <input type="checkbox"/> Intestinal problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Gout | <input type="checkbox"/> Memory loss or confusion |
| <input type="checkbox"/> Bloating, gas, or indigestion | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Nails, poor growth |
| <input type="checkbox"/> Blood Sugar problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nails, white spots |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Colds or flu (frequent) | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Herpes simplex or type II | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> HIV | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Diabetes I (insulin dependent) | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes II (adult onset) | | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Diarrhea | | <input type="checkbox"/> Thyroid condition |
| | | <input type="checkbox"/> Ulcer |
| | | <input type="checkbox"/> Yeast infections |

Women: Please check any that pertain:

- PMS
- Irregular periods
- Painful Periods
- Loss of periods
- Birth control pills
- Loss of libido
- Menopause
- Painful intercourse
- Children
- Hysterectomy

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Men: Please check any that pertain:

- | | |
|---|---|
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Difficulty with Erection |
| <input type="checkbox"/> Difficulty urinating | <input type="checkbox"/> Loss of Libido |
| | <input type="checkbox"/> Prostate Enlargement |

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

Do you exercise?_____ If so, what kind?_____

How often?_____ Since when?_____

Please rate the following:

Daily energy level:

- Excellent
- Good
- Fair
- Poor

Energy level after exercise:

- Excellent
- Good
- Fair
- Poor

Daily stress level:

- Very High
- High
- Moderate
- Low
- None

General enjoyment of life:

- Excellent
- Good
- Fair
- Poor

How much sleep do you get on average each night?_____

Any problems sleeping?_____

Please feel free to expand on any concerns you think are important/relevant to your health._____
