

## **Nutritional Assessment Questionnaire 1.5**

Name:	Date://
Birth Date:	Gender:
Please list your five major health concerns in order of import 1 2 3 4 5	Notes:
PART I Read the following questions and circle the number	
KEY: 0 = Do not consume or use 1 = Consume or use 2 to 3 times monthly	2 = Consume or use weekly 3 = Consume or use daily
DIET 1. 0 1 2 3 Alcohol 7. 0 1 2 3 Cigars/pipes	
2.       0       1       2       3       Artificial sweeteners       8.       0       1       2       3       Caffeinated         3.       0       1       2       3       Candy, desserts, refined sugar       9.       0       1       2       3       Fast foods         4.       0       1       2       3       Carbonated beverages       10.       0       1       2       3       Fried foods         5.       0       1       2       3       Chewing tobacco       12.       0       1       2       3       Margarine         6.       0       1       2       3       Cigarettes       13.       0       1       2       3       Milk product	16. 0 1 2 3       Vitamins and minerals         17. 0 1 2 3       Water, distilled         neats       18. 0 1 2 3       Water, tap         19. 0 1 2 3       Water, well
<ul> <li>21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 tim month)</li> <li>22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12</li> <li>23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years</li> <li>24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 +</li> </ul>	months, 2 = within last 6 months, 3 = within last 2 months) ears, 2 = within last year, 3 = within last 6 months)
25. 0 1Antacids3926. 0 1Antianxiety medications4027. 0 1Antibiotics4128. 0 1Anticonvulsants4129. 0 1Antidepressants4230. 0 1Antifungals4331. 0 1Aspirin/Ibuprofen4432. 0 1Asthma inhalers4533. 0 1Beta blockers4634. 0 1Birth control pills/implant contraceptives4735. 0 1Chemotherapy4836. 0 1Cholesterol lowering medications4937. 0 1Diabetic medications/insulin51	0 1 Thyroid medication 0 1 Acetaminophen (Tylenol)
PART II (See key at bottom of page) Section 1	55

<b>52.</b> 0 1 2 3	Belching or gas within one hour after eating	<b>61.</b> 0 1 2 3	Feel like skipping breakfast
<b>53.</b> 0 1 2 3	Heartburn or acid reflux	<b>62.</b> 0 1 2 3	Feel better if you don't eat
<b>54.</b> 0 1 2 3	Bloating within one hour after eating	<b>63.</b> 0 1 2 3	Sleepy after meals
<b>55.</b> 0 1	Vegan diet (no dairy, meat, fish or eggs) (0=no,	<b>64.</b> 0 1 2 3	Fingernails chip, peel or break easily
	1=yes)	<b>65.</b> 0 1 2 3	Anemia unresponsive to iron
<b>56.</b> 0 1 2 3	Bad breath (halitosis)	<b>66.</b> 0 1 2 3	Stomach pains or cramps
<b>57.</b> 0 1 2 3	Loss of taste for meat	<b>67.</b> 0 1 2 3	Diarrhea, chronic
<b>58.</b> 0 1 2 3	Sweat has a strong odor	<b>68.</b> 0 1 2 3	Diarrhea shortly after meals
<b>59.</b> 0 1 2 3	Stomach upset by taking vitamins	<b>69.</b> 0 1 2 3	Black or tarry colored stools
<b>60.</b> 0 1 2 3	Sense of excess fullness after meals	<b>70.</b> 0 1 2 3	Undigested food in stool

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Sec	tion 2					68
	0 1 2 3	Pain between shoulder blades	85.	0 1		Easily hung over if you were to drink wine (0=no,
72.	0 1 2 3	Stomach upset by greasy foods		•		1=yes)
73.	0123	Greasy or shiny stools	86.	012	3	Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
74.	0123	Nausea	87.	0 1		Recovering alcoholic (0=no, 1=yes)
75.	0123	Sea, car, airplane or motion sickness	88.	0 1		History of drug or alcohol abuse (0=no, 1=yes)
76.	0 1	History of morning sickness (0 = no, 1 = yes)	89.	0 1		History of hepatitis (0=no, 1=yes)
77.	0 1 2 3	Light or clay colored stools	90.	0 1		Long term use of prescription/recreational drugs
78.	0 1 2 3	Dry skin, itchy feet or skin peels on feet				(0=no, 1=yes)
79.	0 1 2 3	Headache over eyes	91.	0 1 2	3	Sensitive to chemicals (perfume, cleaning
80.	0 1 2 3	Gallbladder attacks (0=never, 1=years ago,				agents, etc.)
		2=within last year, 3=within past 3 months)	92.	0 1 2	3	Sensitive to tobacco smoke
81.	0 1	Gallbladder removed (0=no, 1=yes)	93.	0 1 2	3	Exposure to diesel fumes
82.	0123	Bitter taste in mouth, especially after meals				Pain under right side of rib cage
83.	0 1	Become sick if you were to drink wine (0=no,				Hemorrhoids or varicose veins
		1=yes)		012		
84.	0 1	Easily intoxicated if you were to drink wine		0 1 2		
		(0=no, 1=yes)	98.	0 1 2	3	Chronic fatigue or Fibromyalgia
Sec	tion 3					47
99.	0123	Food allergies	108.	012	3	Crohn's disease (0 =no, 1=yes in the past,
100.	0123	Abdominal bloating 1 to 2 hours after eating				2=currently mild condition, 3=severe)
101.	0 1	Specific foods make you tired or bloated (0=no,	109.	012	3	Wheat or grain sensitivity
		1=yes)	110.	012	3	Dairy sensitivity
102.	0123	Pulse speeds after eating	111.	0 1		Are there foods you could not give up (0=no,
	0123	Airborne allergies				1=yes)
	0123	Experience hives	112.	012		Asthma, sinus infections, stuffy nose
	0123	Sinus congestion, "stuffy head"		012		
	0123	Crave bread or noodles				Use over-the-counter pain medications
107.	0123	Alternating constipation and diarrhea	115.	012	3	Feel spacey or unreal
Sec	tion 4					58
116.	0 1 2 3	Anus itches	126.	012	3	Stools have corners or edges, are flat or ribbon
117.	0123	Coated tongue				shaped
118.	0123	Feel worse in moldy or musty place	127.	012	3	Stools are not well formed (loose)
119.	0123	Taken antibiotic for a total accumulated time of	128.	012	3	Irritable bowel or mucus colitis
		(0=never, 1= <1 month, 2= <3 months, 3= >3		0 1 2		Blood in stool
		months)		012		Mucus in stool
	0123	Fungus or yeast infections				Excessive foul smelling lower bowel gas
	0123	Ring worm, "jock itch", "athletes foot", nail fungus		0 1 2		Bad breath or strong body odors
122.	0123	Yeast symptoms increase with sugar, starch or	133.	0 1 2	3	Painful to press along outer sides of thighs
		alcohol				(Iliotibial Band)
		Stools hard or difficult to pass				Cramping in lower abdominal region
	0 1	History of parasites (0=no, 1=yes)	135.	012	3	Dark circles under eyes
125.	0 1 2 3	Less than one bowel movement per day				
Sec	tion 5					75
136.	0 1	History of carpal tunnel syndrome (0=no, 1=yes)	150.			History of bone spurs (0=no, 1=yes)
137.	0 1	History of lower right abdominal pains or		012		Morning stiffness
		ileocecal valve problems (0=no, 1=yes)		0 1 2		Nausea with vomiting
	0 1	History of stress fracture (0=no, 1=yes)				Crave chocolate
139.		Bone loss (reduced density on bone scan)				Feet have a strong odor
140.	0 1	Are you shorter than you used to be? (0=no,				History of anemia
	_	1=yes)		012		Whites of eyes (sclera) blue tinted
	0 1 2 3	Calf, foot or toe cramps at rest		0 1 2		Hoarseness
	0 1 2 3	Cold sores, fever blisters or herpes lesions		0 1 2		Difficulty swallowing
	0 1 2 3	Frequent fevers		012		Lump in throat
	0123	Frequent skin rashes and/or hives		0 1 2		Dry mouth, eyes and/or nose
145.		Herniated disc (0=no, 1=yes)		012		Gag easily White spots on fingernalia
	0123	Excessively flexible joints, "double jointed"		0 1 2		White spots on fingernails
	0123	Joints pop or click		0 1 2 0 1 2		Cuts heal slowly and/or scar easily Decreased sense of taste or smell
	0 1 2 3 0 1 2 3	Pain or swelling in joints Bursitis or tendonitis	104.	012	3	Decieased sense of laste of sineli
143.	0123					

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Secti	on 6				22
167.	0 1 0 1 2 3 0 1 2 3 0 1 2 3	, , ,	170. 171.	0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3	Sunburn easily or suffer sun poisoning Muscles easily fatigued
Secti	on 7				39
174. 175. 176. 177. 178.		Binge or uncontrolled eating Excessive appetite Crave coffee or sugar in the afternoon Sleepy in afternoon	181. 182. 183. 184.	0123	Irritable before meals
Secti	on 8				81
187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198.	$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	Enlarged heart or congestive heart failure	201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211.	$ \begin{smallmatrix} 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 0 & 1 & 2 & 3 \\ 1 & 3 & 3 \\ 1 & 3$	Whole body or limb jerk as falling asleep Night sweats Restless leg syndrome Cracks at corner of mouth (Cheilosis) Fragile skin, easily chaffed, as in shaving Polyps or warts MSG sensitivity Wake up without remembering dreams Small bumps on back of arms Strong light at night irritates eyes Nose bleeds and/or tend to bruise easily
Secti	on 9				78
213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224.	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	•	227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237.	$\begin{array}{cccccccccccccccccccccccccccccccccccc$	Arthritic tendencies Crave salty foods Salt foods before tasting Perspire easily Chronic fatigue, or get drowsy often Afternoon yawning Afternoon headache Asthma, wheezing or difficulty breathing Pain on the medial or inner side of the knee Tendency to sprain ankles or "shin splints" Tendency to need sunglasses Allergies and/or hives
Secti	on 10				29
241. 242. 243.	0 1 0 1 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1	Height over 6' 6" (0=no, 1=yes) Early sexual development (before age 10) (0=no, 1=yes) Increased libido Splitting type headache Memory failing Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)	247. 248. 249. 250.	0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3 0 1 2 3	Excessive thirst Weight gain around hips or waist Menstrual disorders Delayed sexual development (after age 13) (0=no, 1=yes)

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Sect	ion 11						48
	0 1 2 3	Sensitive/allergic to iodine	260.	012	3	Mentally sluggish, reduced initiative	
	0 1 2 3	Difficulty gaining weight, even with large	261.	0 1 2		Easily fatigued, sleepy during the day	
	0.20	appetite	262.	0 1 2			
254.	0 1 2 3	Nervous, emotional, can't work under pressure				and feet)	
	0 1 2 3	Inward trembling	263.	012	3	Constipation, chronic	
	0 1 2 3	Flush easily	264.	0 1 2		Excessive hair loss and/or coarse hair	
	0 1 2 3	Fast pulse at rest	265.			Morning headaches, wear off during the day	
	0 1 2 3	Intolerance to high temperatures	266.	0 1 2		Loss of lateral 1/3 of eyebrow	
	0 1 2 3	Difficulty losing weight	267.	0 1 2		Seasonal sadness	
Sect	ion 12 -	- Men Only					27
268.	0 1 2 3	Prostate problems	272.	012	3	Waking to urinate at night	
269.	0 1 2 3	Difficulty with urination, dribbling	273.	012	3	Interruption of stream during urination	
270.	0 1 2 3	Difficult to start and stop urine stream	274.	012	3		
271.	0 1 2 3	Pain or burning with urination	275.	012	3		
		·	276.	012	3		
Sect	ion 13 -	- Women Only					60
	0123	-	287.	012	3	Breast fibroids, benign masses	
	0 1 2 3	Mood swings associated with periods (PMS)	288.	0 1 2		Painful intercourse (dysparenia)	
279.		Crave chocolate around periods	289.	0 1 2		Vaginal discharge	
	0 1 2 3	Breast tenderness associated with cycle	290.	0 1 2		Vaginal dryness	
		Excessive menstrual flow	291.	012		Vaginal itchiness	
		Scanty blood flow during periods	292.	012		-	
		Occasional skipped periods	293.	012		Excess facial or body hair	
		Variations in menstrual cycles	294.	012		Hot flashes	
	0 1 2 3	Endometriosis	295.	012		Night sweats (in menopausal females)	
	0 1 2 3		296.	0 1 2		Thinning skin	
Sect	ion 14						30
297.	0 1 2 3	Aware of heavy and/or irregular breathing	302.	012	3	Ankles swell, especially at end of day	
298.	0 1 2 3	Discomfort at high altitudes	303.	012	3	Cough at night	
299.	0 1 2 3	"Air hunger" or sigh frequently	304.	012	3	Blush or face turns red for no reason	
300.	0 1 2 3	Compelled to open windows in a closed room	305.	012	3	Dull pain or tightness in chest and/or radiate	
301.	0 1 2 3					into right arm, worse with exertion	
			306.	012	3	Muscle cramps with exertion	
Sect	ion 15						13
307.	0 1 2 3	Pain in mid-back region	310.	0 1 2	3	Cloudy, bloody or darkened urine	
	0 1 2 3		311.	0 1 2			
309.		History of kidney stones (0=no, 1=yes)	••••	0 1 2	Ū		
Sect	ion 16						30
	0123	Runny or drippy nose	317.	012	2	Never get sick (0 = sick only 1 or 2 times in las	st
	0 1 2 3 0 1 2 3	Catch colds at the beginning of winter	517.	U I Z	3	2 years, $1 = \text{not sick in last 2 years, } 2 = \text{not}$	JL
	0 1 2 3	Mucus producing cough				sick in last 4 years, 3 = not sick in last 7 years	`
	0123	Frequent colds or flu (0=1 or less per year, 1=2	318.	0 1 0	0		)
515.	0123	to 3 times per year, 2=4 to 5 times per year, 3=6		012		Acne (adult) Itchy skin (Dermatitis)	
			319. 220	0 1 2			
216	0 4 0 0	or more times per year)	320.	0 1 2		Cysts, boils, rashes	
516.	0123	Other infections (sinus, ear, lung, skin, bladder,	321.	υ12	3	History of Epstein Bar, Mono, Herpes,	_
		kidney, etc.) (0=1 or less per year, 1=2 to 3				Shingles, Chronic Fatigue Syndrome, Hepatitis	
		times per year, 2=4 to 5 times per year, 3=6 or				or other chronic viral condition $(0 = no, 1 = yes)$	5
		times per year, 2=4 to 5 times per year, 3=6 or more times per year)				or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)	5

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