POSITIVE PATTERNS FOR LIFE
HEALTH and NUTRITION QUESTIONNAIRE

Name _____ Age _____ Gender _____

Address _____

Phone _____ Email _____ Date _____

I – PRIMARY HEALTH ISSUE/CONCERNS

A - Describe your most troublesome health issues and greatest health concerns:

#1 Issue/Condition and Date of Onset: What symptoms do you experience with this health issue/condition? How are you currently taking care of yourself with this health issue/condition? Is there anything that makes symptoms better or worse?
2 Issue/Condition and Date of Onset: What symptoms do you experience with this health issue/condition? How are you currently taking care of yourself with this health issue/condition? Is there anything that makes symptoms better or worse?
#3 Issue/Condition and Date of Onset: What symptoms do you experience with this health issue/condition? How are you currently taking care of yourself with this health issue/condition? Is there anything that makes symptoms better or worse?

B – Do you have any other health issues/conditions at this time that you would like me to know about? If yes, please describe:

C – Are there any other medical problems that run in the family? If yes, please explain:

D – Do you take any prescription medications? Please list below:

Medication	Dose/Frequency	Medication Action	Duration
Any side effects?			
Any side effects?			
Any side effects?			
Any side effects?			
Any side effects?			
Any side effects?			
Any side effects?			

E – Do you take any supplements? Please list vitamins, minerals, and herbs below:

Supplement	Dose/Frequency	Reason for taking supplement?	Duration
Results?			
Results?			
Results?			
Results?			
Results?			
Results?			
Results?			

F – Do you take any over-the-counter medications on a regular basis?

II – NUTRITION HISTORY

A – Height: _____ **Current Weight:** _____ **Desired Weight:** _____

B – Eating Habits

How many meals do you eat per day?

Do you have regular meal times?

Do you sit at a table to eat and focus on enjoying your meal?

Do you eat slowly and chew your food well?

Do you snack between meals? If yes, on what?

Do you eat meals cooked from scratch or meals out of a box (i.e. frozen dinners)?

How many times do you eat "fast foods" each week?

How many glasses of water do you drink during a typical day?

What else do you drink in addition to water?

Are there certain foods you eat to cope with stress or emotions? If yes, which ones?

Do you experience food cravings? If yes, for what food(s)?

Do you feel like you binge on some foods (eat an excessive number of servings at one time)?

What is your relationship with sugar?

Do you use artificial sweeteners? If so, which ones and how often?

C – Digestive Health

Are you currently on a special diet? If yes, please explain:

Do you have any food restrictions? If yes, please explain:

Do you have foods allergies or sensitivities? If yes, please explain:

Do you have at least 1 bowel movement per day? YES NO, how often?

Do you have any of the following gastrointestinal problems? Check all that apply and indicate frequency [D=daily; W=weekly; M=monthly]:

- ☐ Abdominal pain: D W M
- ☐ Indigestion: D W M
- ☐ Excessive Belching: D W M
- ☐ Bloated abdomen: D W M
- ☐ Nausea: D W M
- ☐ Vomiting: D W M
- ☐ Acid reflux: D W M
- ☐ Heartburn: D W M
- ☐ Abdominal cramps: D W M
- ☐ Irritable Bowel Syndrome: D W M
- ☐ Mucus in the stools: D W M
- ☐ Constipation: D W M
- ☐ Diarrhea: D W M
- ☐ Foul smelling gas: D W M
- ☐ Undigested food in the stools: D W M
- ☐ Gassy: D W M

III - LIFESTYLE HISTORY

A – Activities of Daily Living

What type of movement or physical activity do you get during your daily routine?

Do you exercise on purpose? If yes, describe type of exercise, intensity, duration, and frequency:

What do you do for a living?

Number of work hours per week?

Do you like your current job?

B - Health Support

What is your living situation and who do you live with (include pets)?

Do you feel like your home environment supports your health and healing?

Do you have friends or family who are supportive of you during the healing process?

Do you have adequate health insurance?

C – Stress – Rest - Relaxation

How much sleep do you get on an average night?

Describe the quality of sleep:

What do you do to relax and how often do you take time to relax?

Do you have quality (enjoyable) time with family and friends?

Do you have stress in your life?
If yes, what are the greatest source(s) of stress in your life?

How does stress affect your physical and mental health?

How do you cope with stressful situations?

What actions do you take to purposefully de-stress?

IV - CONCLUSION

How would you describe peak health?

Do you feel like your body is in peak health?
If no, please explain:

If no, please describe how you would like your body to feel and perform:

Would you be willing to make changes in your current lifestyle and nutrition habits, if you believed it would help you achieve peak health?

What do you hope to achieve by working together with me?

PLEASE EMAIL THIS COMPLETED FORM TO POSITIVEPATTERNSFORLIFE@GMAIL.COM.