Nutrition Questionnaire

PRIVATE AND CONFIDENTIAL

This questionnaire is designed to provide your nutritionist with all the information necessary to build an individual nutritional program specifically tailored to your needs. Please answer the questions as accurately as possible.

Date _____

Name

_____

Address

_____

_____

Best Telephone Number

_____

Occupation

_____

Height _____ Weight _____ Age_____

Date of Birth: _____

Email Address_____

Nutrition Questionnaire

Health Profile

List all health issues you would like to work on and indicate how long you have had these symptoms. e.g.: Headaches / 5 years

Health Concerns

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

What medicationsdo you take for these issues? State daily dosage.

_____

_____

Under what circumstances do these problems improve?

_____

_____

Under what circumstances do they worsen?

_____

What other illnesses have you had in the past five years?

_____

_____

Nutrition Program Questionnaire

What operations have you had?

_____

_____

What is your normal blood pressure? (Leave blank if unknown)

_____

What is your resting heart rate per minute?

_____

(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

Fitness Profile

How much do you work out/exercise on a weekly basis?

_____

What activities are you interested in improving?

_____

_____

How would you measure your current level in this activity? Circle one.

Casual / Amateur / Semi-pro / Pro / Weekend warrior

Do you feel better? After meals / Before meals

What kind of meals lead you to optimal performance?

_____

_____

Nutrition Questionnaire

SYMPTOMS ANALYSIS

Each symptom in this section can be associated with a nutritional deficiency. Please circle the conditions from which you often suffer and are looking to improve upon.

Mouth ulcers

Acne

Dry flaky skin

Dandruff

Thrush or cystitis

Diarrhea

Frequent Urination

Backache

Tooth decay

Hair loss

Muscle cramps or spasms

Joint pain/Stiffness/Arthritis

Lack of energy

Exhaustion after light exercise

Easy bruising

Varicose veins

Loss of muscle tone

Frequent colds

Frequent infections

Bleeding or tender gums

Easy bruising

Nose bleeds

Slow wound healing

Red pimples on skin

Tender muscles

Poor concentration

Poor memory

Stomach pains

Constipation

Overweight

Tingling hands

Dull or oily hair

Eczema or Dermatitis

Split nails

Cracked lips

Insomnia

Headaches or migraines

Depression

Irritability

Muscle tremors or cramps

Burning feet or tender heels

Nausea or vomiting

Anxiety or tension

Water retention

Prematurely graying hair

Poor appetite

Dry eyes

PMS or breast pain

Insomnia or nervousness

High blood pressure

Muscle weakness

High blood pressure

Irregular heartbeat

Hyperactivity

Tendency to depression

Sore knees

Excessive or cold sweats

'Addicted' to or craving sweet foods

LIFESTYLE ANALYSIS

Check any of the following that apply to you.

Cardiovascular

_____Is your blood pressure above 140/90?

_____ Is your pulse after 15 minutes rest above 75?

_____ Are you more than 14lbs (7kg) over your ideal weight?

_____ Do you smoke more than 5 cigarettes per day?

_____ Do you do less than two hours exercise per week?

_____ Do you usually add salt to your food (if yes, what kind)? _____

_____ Do you have more than 2 alcoholic drinks per day?

_____ Is there a history of heart disease in your family?

_____ Is there a history of diabetes in your family?

_____ Is there a history of cancer in your family?

If yes to cancer, what kind?_____

Acid/Toxin Profile

_____Do you drink bottled water?

_____Do you consume dairy (if yes, what kind)?_____

_____Do you consume meat (if yes, how many times per week)? _____ _____Do

you eat bread/pasta (if yes, how often)?_____

_____ Do you eat more than one spoonful of sugar per day?

_____Do you consume coffee, soda, caffeinated tea, or carbonated water (circle any that apply)?

_____Do you drink more than 1 unit or oz of alcohol per day?

(1 glass of wine, 1 pint of beer, or 1 measure of spirits)

_____ Do you spend a lot of time in front of a TV or computer?

Nutrition Questionnaire

Glucose Tolerance

_____ Do you need more than 8 hours sleep per night?

_____ Are you rarely wide awake within 20 minutes of rising?

_____ Do you need something to get going in the morning, tea or coffee?

_____ Do you get dizzy or irritable if you don't eat often?

_____ Do you avoid exercise due to tiredness?

_____ Do you sweat a lot or get excessively thirsty?

_____ Do you sometimes lose concentration?

_____ Rate your energy, 0 being no energy, 10 being unstoppable energy

Digestion

_____ Do you chew your food thoroughly?

_____ Do you sometimes suffer from bad breath?

_____ Are you prone to stomach upsets?

_____ Do you often get a burning sensation in your stomach?

_____ Do you find it difficult digesting fatty foods?

_____Do you suffer from acid reflux?

_____ Do you occasionally use indigestion tablets?

_____ Do you suffer from flatulence or bloating?

_____ Do you experience anal irritation?

_____ Do you have a bowel movement daily?

_____ Do your stools float?

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Immune

_____ Do you get more than three colds per year?

_____ Do you find it hard to shift an infection (cold or otherwise)?

_____ Are you prone to thrush or cystitis?

_____ Do you often take antibiotics more than twice per year?

_____ Have you ever had any growths or lumps biopsies?

_____ Do you have an inflammatory disease, eczema, asthma or arthritis?

_____ Do you suffer from hay fever?

_____ Do you suffer from allergies?

_____ Have you had a major personal loss in the last year?

Allergies

Circle any of the following that apply to you.

Sleep over 8 hours	'Morning person'
Little sex drive	Sleep less than 7 hours
Much body hair	Little body hair
Sluggish metabolism	Tends towards depression
Slow to wake up	Don't put on weight
Fast metabolism	Poor tolerance to pain

Do you have allergies? YES NO

Nutrition Questionnaire

If YES, to what? _____ Do you suffer from any of the following? Circle all that apply.

Nasal problems	Dermatitis	Irritable bowel syndrome
Hay fever	Asthma	Frequent bloating
Eczema	Migraine	Facial puffiness

Have you been tested?

_____

What does your current daily diet look like (what does a typical day look like from waking to sleep)

_____

_____

_____

What food or drinks would you find hard to give up?

_____

_____

List all food supplements and medication you are currently taking.

_____

_____

_____

_____

_____

What are your GOALS/OUTCOMES for this visit in regard to your health?

_____

_____

DIET ANALYSIS

Check for 'yes' or fill in the number.

1. _____ Were you breast fed?
2. _____ As a child, was a significant part of your diet high in fatty foods and sugar?
3. _____ Do you strongly avoid foods containing preservatives or additives?
4. _____ Do you use salt in your cooking?
5. _____ How many coffees do you drink each day?
6. _____ How many cups of tea do you drink each day?
7. _____ How many times/week do you have meals containing fried food?
8. _____ How many packets of 'instant' or fast foods do you at each week?
9. _____ How many times a week do you eat chocolate or confectionery?
10. _____ What percentage of your diet is raw fruit and raw vegetables?
11. _____ Do you wash fruit and vegetables before eating?
12. _____ Do you normally eat white rice or flour?
13. _____ How many glasses of milk do you drink in a week?
14. _____ How many times/week do you eat live yogurt?
15. _____ Do you drink filtered water instead of tap water?
16. _____ Do you frequently eat under stressful conditions or on the move?
17. _____ Does your job involve eating out a frequently?
18. _____ How would you describe your appetite? (a) Poor (b) Average (c) Good (d) Outstanding
19. _____On a scale of 0-10 (10 being MOST, 0 being the LEAST), how would you rate your health?
20. _____On a scale of 0-10 (10 being MOST, 0 being the LEAST), how would you rate your motivation to improve your health and desired outcome you mentioned?

Nutrition Questionnaire

Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me.

I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature:_____ Date: _____

Parent or Legal Guardian Signature (if patient is a minor):_____