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Health Questionnaire

Name:____ Today's Date:__________________
Address:____
City: ______________________________________ State: ____________Zip:__________________
Email address: _______________________________ Monthly Newsletter? Y / N
Best Phone:__________________ May I leave detailed messages?______________________________
What is your preferred method of contact? ____
How did you find out about me? ____
Height:________ Weight: ________ Ideal Weight: ________
Highest Adult weight: ________ Year: _____ Lowest Adult Weight: ________ Year: _____
☐ Male ☐ Female DOB: ________________ Place of Birth: ______________________________
Genetic background: ☐ African American ☐ Native American ☐ Mediterranean ☐ Asian
☐ Caucasian ☐ Northern European ☐ Other ____________________

What would you like help with at this time?

Please list your health concerns: **How long have you had these conditions?**

1.____ ______________________________
2.____ ______________________________
3.____ ______________________________
4.____ ______________________________
5. ____ ______________________________

Name and contact information for Primary Physician: ______________________________
____

Please list other practitioners that you are seeing: ____
____

Family History:

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children		

Comments on family health history: ____
____

Medications and Supplements: *Please list all **prescription medications** and **nutritional supplements, herbs** you are currently taking. Use a separate sheet if needed.*

Medications	Name	Dosage	Frequency	Length of time	Purpose

Supplements	Name	Dosage	Frequency	Length of time	Purpose

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, tylenol, antibiotics, etc)? ____

____

List major traumas, major or minor surgeries, and hospitalizations? ________________

____

____

Physical Activity and Lifestyle

What kind of physical activities do you do? ____

Are you satisfied with your energy level? ____

Are there any problems/limitations that inhibit your physical activity? ____________________________

Activity	Type(s)	Days per week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

What do you do for relaxation? ____

How many hours of sleep do you get a night/day? _________ Do you sleep well? _____________________

Relationship Status: _________________

Current Occupation:________________________ How many years? ________ Hours per week?_________

Do you like your work? ____

Passions/Interests? ____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your

Work: _______ Current health status: ________ Social/family situation:________ Life in general:_______

What do you believe you can do to make a difference in your current health? ________________________

____

Nutrition

Have you ever had a nutritional consult?____

Please list **food** allergies: ____

Please list **non-food** and **environmental** allergies: ______________________________________

Please list any special dietary restrictions/habits you have: ___________________________________

____

What foods do you crave if anything? ____

What are your favorite foods? ____

Where do you grocery shop? ____

Please describe any changes you have made to your diet to improve your health? _______________

____

How would you describe your relationship to food? ______________________________________

____

Food Frequency: How often do you eat or do the following? *Insert a number and circle **day** or **week***

Meals per day: ______	Red Meat: _____ x d / wk
Snacks per day: ______	Chicken/Turkey: _____ x d / wk
Water _________ ounces per day	Deli Meat: _____ x d / wk
Prepare meals: ______ x d / wk	Fish: _____ x d / wk
Nuts/Seeds: _____ x d / wk	Shellfish: ______ x d / wk
Lentils/Beans: _____ x d / wk	Organ meat: _____ x d / wk
Yogurt: _____ x d / wk	Soy products _____ x d / wk
Fats and oils: _____ x d / wk *What kinds?*________	Eggs: ________ x d / wk
Dairy Milk/Cheese: _______x d / wk	ALL VEGGIES: ______ x d / wk
Other Milk: _____ x d / wk	ALL FRUIT: ______ x d / wk
Bread: _____ x d / wk	Coffee: ______ x d / wk, decaf? _________
Whole Grains: _____ x d / wk	Herb or other Tea: ______ x d / wk
Pasta: _____ x d / wk	Soft Drinks: ______ x d / wk, diet OR regular
Chips/crackers etc.: _____ x d / wk	Frozen Dinners: ______ x d / wk
Candy: ______ x d / wk	Alcoholic Drinks: _______ x d / wk
Fast Food: ______ x d / wk	Eat fast or on the run: _______ x d / wk

NUTRITION: 3-Day Food Diary

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior, the purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Symptom Review: Please check symptoms noticed in the past year. Any major problems that you had previously, but no longer have, mark with a "P"

Section 1	
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2	
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3	
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Bitter taste in mouth, especially after meals	
Easily intoxicated or hung if you were to drink wine	
Pain under right side of rib cage	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4	
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food (s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic foods (s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn's disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5	
Catch colds at the beginning of winter	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Experienced a mucous producing cough	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic viral conditions	
Have food allergies or sensitivities	

Section 6	
Coating on your tongue	
Anus itches	
Fungus or yeast infections	
Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or mucous colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7	
Eat less than five servings of (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day	
Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon	
Sleepy in the afternoon	
Fatigue is relieved by eating	
Binging or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are skipped or delayed	
Heart palpitations after eating sweets	
Have frequent thirst	
Have frequent urination	
Once you start eating sweets or carbohydrates, do you feel you can’t stop	
Tend to gain weight in the belly	
Have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism or a family history of any one of these	
Have elevated triglycerides or cholesterol	
Have high blood pressure	

Section 8	
Have high or low blood pressure	
Have a low libido	
Have trouble falling asleep	
Get less than 8 hours a sleep a night	
Go to bed frequently after midnight	
Get less than 1 hour a day of sunlight	
Work the night shift	
Are you an emotional eater	

Feel anxious or have panic attacks	
Are you a shallow breather	
Experience heart palpitations	
Cravings for salt or sweets	
Experience chronic or prolonged fatigue	
Does fatigue prevent you from doing things you would like to do. Interfere with you work, family or social life	
Do you feel you can’t get started in the morning without coffee or caffeinated drinks	

Section 9	
Are you cold when everyone else is warm	
Have course or brittle hair	
Experience constipation	
Have thinning hair or hair loss	
Experienced a loss of sex drive	
Lost the outside of your eyebrow	
Experience depression	
Have trouble losing weight	
Have a low blood pressure or heart rate	
Have elevated cholesterol	
Have a hoarse voice	
Have dry, scaly skin	
Have cold hands and feet	
Experience fatigue	
Experience fluid retention	

Section 10	
Aware of irregular or heavy breathing	
Experienced discomfort at high altitudes	
Sigh frequently or “air hunger”	
Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at end of day	
Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiate into left arm, worse on exertion	
Have muscle cramps on exertion	

Section 11	
Rarely break out into a sweat	
Use aluminum cooking equipment	
Have mercury amalgams	
Heat food in plastic containers in microwave	
Have your clothes dry-cleaned	
Eat “fast-food” > 2 times a week	
Drink tap, well or bottled water	
Have strong body odor	
Have acne on face or buttocks	
Drink < 4 cups water a day (approximately 30 oz)	
Live in a large urban or industrial area	
Use lawn or garden chemicals	
Have less < 1 bowel movement per day	
React to small amounts of alcohol	
Sit on your computer 3+ hours a day	
Exercise < 3 times a week	

Use tobacco products	
Eat large fish (sword fish, tuna, shark, tilefish) more than once a week	
Urinate small amounts of dark urine only a few times a day	
Frequently exposed to solvents and chemicals at work or at home	
Feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine	
Have a negative reaction when you consume foods containing MSG, sulfites or other preservatives	