Nutritional Assessment Questionnaire

Name:_____ **Date:**_____

Address:_____ **Gender:**_____

_____ **Telephone:**_____

Emergency Contact Name / Number: _____/_____

Please list your top major health concerns in order of importance:

1._____

2._____

3._____

Please circle if you have the following: Organ Transplant / Shunt / Stint / Cadaver Bone / Live Tissue / Pace Maker

Have you ever had a seizure? Yes / No

DENTAL: Do you have tooth implants, amalgam fillings, root canal, bridges, or any other metal in your mouth? Yes / No

SURGERIES: Type: _____ **Year:** _____

PART 1

Read the following questions and fill in the number that applies:
KEY: 0 (or blank) = do not consume or use 2 = Consume or use weekly
1 = Consume or use 2-3 times/month 3 = Consume or use daily

DIET

	Alcohol		**Coffee**		**Refined flour/Baked Goods**
	Artificial Sweeteners		**Eat Fast Food regularly**		**Refined Sugar**
	Candy or other sweets		**Fried Foods**		**Vitamins and Minerals**
	Carbonated beverages		**Luncheon meats/hot dogs**		**Water, distilled**
	Chewing tobacco		**Margarine**		**Water, Tap**
	Cigarettes		**Milk Products**		**Water, Well**
	Cigars/pipes		**Non-herbal Tea**		**Diet often**

LIFESTYLE

	Times you exercise per week (1 = once a week, 2 = 2 – 4 times per week, 3= t times per week)
	Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months)
	Divorced (3= within lasts 6 months, 2= within last year, 1=within last 2 years)
	Work over 60 hours per week (3= always, 2= usually, 1=occasionally, 0= never)

MEDICATIONS – Indicate with an X with any medications currently taken or have taken in last month

	Antacids		**Asthma Inhalers**		**Estrogen/Progesterone**		**Oral/implant contraceptives**
	Antibiotics		**Beta Blockers**		**Heart Medications**		**Radiation exposure**
	Anticonvulsants		**Chemotherapy**		**High Blood Pressure**		**Recreational drugs**
	Antidepressants		**Cortisone**		**Hormone Therapy**		**Relaxants/Sleeping pills**
	Antifungals		**Diabetic Medications**		**Laxatives**		**Thyroid medication**
	Aspirin/ibuprofen		**Diuretics**		**Insulin**		**Tylenol/acetaminophen**
							Ulcer medications

Other medications and dosages:_____

Key: 0 = No or do not have symptom, symptom does not occur
1 = Yes or Minor or Mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Sever symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

PART 2
Read the following questions and fill in the number that applies:
(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true)

KEY: **0 (or blank) = No or do not have the symptom, the symptom does not occur**
1 = Yes or it is a minor or mild symptom or it rarely occurs (once a month or less)
2 = It is a moderate symptom or it occasionally occurs (weekly)
3 = It is a severe symptom or it frequently occurs (daily)

SECTION 1 – Upper Gastrointestinal System

	Belching or gas within 1 hour of meal		**Do you feel like skipping breakfast?**
	Heartburn or acid reflux		**Do you feel better if you don't eat?**
	Bloating shortly after eating		**Sleepy after meals**
	Vegan (no dairy, meat, fish or eggs)		**Fingernails chip, peel or break easily**
	Bad breath (halitosis)		**Anemia unresponsive to iron**
	Loss of taste for meat		**Stomach pains or cramps**
	Sweat has a strong odor		**Diarrhea, chronic**
	Stomach upset by taking vitamins		**Diarrhea shortly after meals**
	Sense of excess fullness after meals		**Black or tarry stools**
			Undigested food in stool

SECTION 2 – Liver and Gallbladder

	Pain between shoulder blades		**Alcoholic beverages per week (0=<3/week, 1=<7/week, 2=<14 week, 3=>14 week**
	Stomach upset by greasy foods		**Recovering alcoholic (1=yes, 0=no)**
	Greasy or shiny stools		**Hangovers after drinking alcohol**
	Nausea		**History of drug or alcohol abuse (1=yes, 2=no)**
	Sea, car or airplane sickness/motion sickness		**History of hepatitis (1=yes, 2=no)**
	History of morning sickness (1=yes, 2=no)		**Long term use of prescription meds (1=yes, 2=no)**
	Light or clay colored stools		**Sensitive to chemicals (perfume, cleans solvents, exhaust)**
	Dry skin, itchy feet and/or skin peels on feet		**Sensitive to tobacco smoke**
	Headache over eye		**Exposure to diesel fumes**
	Gallbladder attacks (past or present)		**Pain under right side of rib cage**
	Gallbladder removed (1=yes, 2=no)		**Hemorrhoids or varicose veins**
	Bitter taste in mouth, especially after meals		**Nutrasweet (aspartame) consumption**
	Become sick if drinking wine		**Bothered by aspartame (Nutrasweet)**
	If drinking alcohol, easily intoxicated		**Chronic fatigue or Fibromyalgia**

SECTION 3- Small Intestine

	Food Allergies		**Crohn's disease (1 = yes, 0 = no)**
	Abdominal bloating 1 to 2 hours after eating		**Wheat or grain sensitivity**
	Specific foods make you tired or bloated (1=yes)		**Dairy sensitivity**
	Pulse speeds after eating		**Are there foods you could not give up (1=yes, 0=no)**
	Airborne allergies		**Asthma, sinus infections, stuffy nose**
	Experience hives		**Bizarre vivid or nightmarish dreams**
	Sinus congestion, "stuffy head"		**Use over-the-counter pain medications**
	Crave bread or noodles		**Feel spacey or unreal**
	Alternating constipation and diarrhea		

SECTION 4 – Large Intestine

	Anus itches		**Less than one bowel movement per day**
	Coated tongue		**Stools have corners or edges, are flat or ribbon shaped**
	Feel worse in moldy or musty places		**Stools are not well formed (loose)**
	Taken any antibiotic for a combined time of (1= <month, 2= < 3 months, 3= < > 3 months)		**Irritable bowel or mucus colitis**
	Fungus or yeast infections		**Blood in stool**
	Ring worm, "jock itch", "athlete's foot", nail fungus		**Mucus in stool**
	Eating sugar, starch or drinking alcohol increase yeast symptoms		**Excessive foul smelling lower bowel gas**
	Stools hard or difficult to pass		**Cramping in lower abdominal region**
	History of parasites (1 = yes, 0 = no)		**Dark circles under eyes**

Key: 0 = No or do not have symptom, symptom does not occur
1 = Yes or Minor or Mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Sever symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

SECTION 5 – Mineral Needs

	History of Carpal Tunnel Syndrome (1=y, 0=n)		**Morning stiffness**
	History of lower right abdominal pain (1=y, 0=n)		**Vomiting or nausea**
	History of stress fractures		**Crave chocolate**
	Bone loss (reduced density on bone scan)		**Feet have a strong odor**
	Are you shorter than you used to be? (1=y, 0=n)		**Tendency to anemia**
	Calf, foot or toe cramps at rest		**Whites of eyes are blue tinted**
	Cold sores, fever blisters or herpes lesions		**Hoarseness**
	Frequent fevers		**Difficulty swallowing**
	Frequent skin rashes and/or hives		**Lump in throat**
	Have you ever had a herniated disc? (1=y, 0=n)		**Dry mouth, eyes and/or nose**
	Excessively flexible joints, "double jointed"		**Gag easily**
	Joints pop or click		**White spots on fingernails**
	Pain or swelling in joints		**Cuts heal slowly and/or scar easily**
	Bursitis or tendonitis		**Decreased sense of taste or smell**
	History of bone spurs (1=y, 0=n)		

SECTION 6 – Essential Fatty Acids

	Aspirin is an effective pain reliever (1=y, 0=n)		**Headaches when out in the hot sun**
	Crave fatty or greasy foods		**Sunburn easily or suffer sun poisoning**
	Low or reduced fat diet (past or present)		**Muscles easily fatigued**
	Tension headaches at base of skull		**Dry flaky skin and or dandruff**

SECTION 7 – Sugar Handling

	Awaken a few hours after falling asleep, hard to get back to sleep		**Fatigue that is relieved by eating**
	Crave sweets		**Headache if meals are skipped or delayed**
	Eat desserts or sugary snacks		**Irritable before meals**
	Binge or uncontrolled eating		**Shaky if meals delayed**
	Excessive appetite		**Family members with diabetes (0= non, 1= 2 or less, 2=between 2-4, 3=more than 4)**
	Crave coffee or sugar in afternoon		**Frequent thirst**
	Sleepy in afternoon		**Frequent urination**

SECTION 8 – Vitamin Need

	Muscles become easily fatigued		**Can hear heart beat on pillow at night**
	Feel worse, sore after moderate exercise		**Whole body or limb jerk as falling asleep**
	Vulnerable to insect bites		**Night sweats**
	Loss of muscle tone, heaviness in arms/legs		**Restless leg syndrome**
	Enlarged heart, or heart failure		**Chellosis (cracks in corner of mouth)**
	Pulse slow/ below 65 (1=y, 0=n)		**Fragile skin, easily chaffed, as in shaving**
	Ringing in ears / Tinnitus		**Polyps or warts**
	Numbness, tingling or itching in extremities		**MSG sensitivity**
	Depressed		**Wake up without remembering dreams**
	Fear of impending doom		**Take birth control pills**
	Worrier, apprehensive, anxious		**Small bumps on back of arms**
	Nervous or agitated		**Strong light at night irritates eyes**
	Feelings or insecurity		**Nose bleeds and/or tend to bruise easily**
	Heart races		**Bleeding gums, especially when brushing teeth**

Key: 0 = No or do not have symptom, symptom does not occur
1 = Yes or Minor or Mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Sever symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

SECTION 9 – Adrenal

	Tend to be a "night person"		**Arthritic tendencies**
	Difficulty falling asleep		**Crave salty foods**
	Slow starter in the morning		**Salt foods before tasting**
	Keyed up, trouble calming down		**Perspire easily**
	High blood pressure (normal 120/80)		**Chronic fatigue, or get drowsy often**
	Headache after exercising		**Afternoon yawning**
	Feeling wired or jittery if drinking coffee		**Afternoon headache**
	Clench or grind teeth		**Asthma, wheezing or difficulty breathing**
	Calm on the outside, troubled on the inside		**Pain on the medial or inner side of knee**
	Chronic low back pain, worse with fatigue		**Tendency to sprain ankles or "shin splints"**
	Become dizzy when standing up suddenly		**Tendency to need to wear sunglasses**
	Difficult maintaining manipulative correction		**Allergies and/or hives**
	Pain after manipulative correction		**Weakness, dizziness**

SECTION 10 – Pituitary

	Over 5'6" tall (mature height)		**Under 4'10" tall (mature height)**
	Early sexual development <10 years (1=y, 0p=n)		**Decreased libido**
	Increased libido		**Abnormal thirst**
	Splitting type headache		**Weight gain around hips or waist**
	Memory failing		**Menstrual disorders**
	Ability to tolerate sugar		**Delayed (after 13) sexual development (y=1, 2=n)**
			Tendency to ulcers or colitis

SECTION 11 – Thyroid

	Allergic to iodine		**Mentally sluggish, reduced initiative**
	Difficulty gaining weight, even with large appetite		**Easily fatigued, sleepy during the day**
	Nervous, emotional, can't work under pressure		**Sensitive to cold, poor circulation (cold hands and feet)**
	Inward trembling		**Constipation, chronic**
	Flush easily		**Excessive hair loss and/or coarse hair**
	Fast pulse at rest		**Morning headaches, wear off during the day**
	Intolerance to high temperatures		**Loss of lateral 1/3 of eyebrow**
	Difficulty losing weight		**Seasonal sadness**

SECTION 12 – Men Only

	Prostate problems		**Waking to urinate at night**
	Urination difficult or dribbling		**Interruption of stream during urination**
	Difficult to start and stop urine stream		**Pain on inside of legs or heels**
	Pain or burning with urination		**Felling of incomplete bowel evacuation**
			Decreased sexual function

SECTION 13 – Women Only

	Depression during periods		**Breast fibroids, benign masses**
	Mood swings associated with periods (PMS)		**Painful intercourse (dyspareunia)**
	Crave chocolate around periods		**Vaginal discharge**
	Breast tenderness associated with cycle		**Vaginal dryness**
	Excessive menstrual flow		**Vaginal itchiness**
	Scanty blood flow during periods		**Gain weight around hips, thighs and buttocks**
	Occasional skipped periods		**Excess facial or body hair**
	Variations in menstrual cycles		**Hot flashes**
	Endometriosis		**Night sweats (in menopausal females)**
	Uterine fibroids		**Thinning skin**

Key: 0 = No or do not have symptom, symptom does not occur
1 = Yes or Minor or Mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Sever symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

SECTION 14 – Cardiovascular

	Aware of heavy and/or irregular breathing		**Ankles swell, especially at end of day**
	Discomfort at high altitudes		**Cough at night**
	"Air hunger" and/or yawn frequently		**Blush or face turns red for no reason**
	Compelled to open windows in a closed room		**Dull pain or tightness in chest and/or radiate into right arm, worse with exertion**
	Shortness of breath with moderate exertion		**Muscle cramps with exertion**

SECTION 15 – Kidney and Bladder

	Pain in mid back region		**Cloudy, bloody or darkened urine**
	Dark circles under eyes and/or puffy eyes		**Urine has a strong odor**
	History of kidney stones (1=yes, 0=no)		

SECTION 16 – Immune system

	Runny or drippy nose		**Acne (adult)**
	Catch colds at the beginning of winter		**Itchy skin / dermatitis**
	Mucus producing cough		**Cysts, boils, rashes**
	Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)		**History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis, or other chronic viral conditions (1=yes, 0=no)**
	Frequent colds or flu		
	Never get sick (3 = not I last 7 years, 2 = not in last 4 years, 1 = not in last 2 years)		

Key: 0 = No or do not have symptom, symptom does not occur
1 = Yes or Minor or Mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
3 = Sever symptom, frequently occurs (daily)