2\

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| --- | --- |
|  Patient Questionnaire | Date: |
| Name |  |
| Preferred Name |  |
| Date of Birth |  | Age: | Gender: M F Other:  |
| Primary Address |  |
| Preferred Primary Phone |  |
| Fax |  |
| Email Address |  |
| Best way to contact you? | Email Phone Leave a message? Y N |
| Primary Physician | *Name:* | *City:* |

What do you hope to achieve in your visit?

How would you rate your current health?

Excellent Very Good Good Fair Poor List your three main health/nutrition concerns:

1.

2.

 3. When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Comments:

Please list food allergies:

Please list non-food allergies including medications/supplements:

Please list environmental allergies:

What type of allergic symptoms do you experience?

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure,*

*overweight, lung disease, kidney disease, diabetes, mental illness or addiction, etc.*

|  |  |
| --- | --- |
| *Family Member:* | *Health Condition:* |
| *Family Member:* | *Health Condition:* |
| *Family Member:* | *Health Condition:* |
| *Family Member:* | *Health Condition:* |

Known Genetic Disorders: Comments:

*Please check the conditions your doctor has diagnosed.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gastrointestinal | Now | Past | Inflammatory / Autoimmune | Now | Past |
| Celiac disease |  |  | Chronic fatigue syndrome |  |  |
| Crohn's disease |  |  |
| Gastric or Peptic ulcer disease |  |  | Epstein-Barr Virus |  |  |
| GERD/heartburn/reflux |  |  | Graves’ disease |  |  |
| IBS-D; IBS-C or IBS-Mixed |  |  | Gout |  |  |
| Liver Disease |  |  | Hashimoto's thyroiditis |  |  |
| Small Intestinal Bacterial Overgrowth (SIBO) |  |  | Herpes |  |  |
| Lupus, SLE |  |  |
| Ulcerative colitis |  |  | Poor immune function (frequent infections) |  |  |
| Other: |  |  |
| Rheumatoid arthritis |  |  |
| Respiratory | Now | Past | Other: |  |  |
| Asthma |  |  | Musculoskeletal / Pain | Now | Past |
| Bronchitis |  |  |
| Chronic sinusitis |  |  | Chronic pain |  |  |
| Emphysema |  |  | Fibromyalgia |  |  |
| Pneumonia |  |  | Migraines |  |  |
| Sleep apnea |  |  | Osteoarthritis |  |  |
| COVID-19 |  |  | Other: |  |  |
| Other: |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Cardiovascular | Now | Past | Cancer | Now | Past |
| Atherosclerosis |  |  | Cancer *(please describe type and treatment)* |
| Elevated cholesterol |  |  |
| Heart attack |  |  |
| High blood pressure |  |  | Metabolic / Endocrine | Now | Past |
| Neurological/Brain | Now | Past | Hypoglycemia |  |  |
| Hypothyroidism (low thyroid) |  |  |
| ADD/ADHD |  |  |
| Alzheimer's disease |  |  | Hyperthyroidism (over active thyroid |  |  |
| ALS |  |  |
| Anorexia |  |  | Infertility |  |  |
| Anxiety |  |  | Metabolic syndrome (pre- diabetes, insulin resistance) |  |  |
| Asperger’s |  |  |
| Autism |  |  | Polycystic ovarian syndrome (PCOS) |  |  |
| Bulimia |  |  |
| Eating disorder, unspecified |  |  | Other: |  |  |
| Memory problems |  |  |
| Parkinson's disease |  |  | Dermatological | Now | Past |
| Seizures |  |  |
| Stroke |  |  | Acne |  |  |
| Other: |  |  | Eczema |  |  |
| Other |  |  |

Describe any additional health concerns or medical diagnoses:



|  |  |  |  |
| --- | --- | --- | --- |
| Do you visit a dentist regularly (twice per year)? | Y | N |  |
| Do you have any silver/mercury amalgam fillings? | Y | N | *If yes, how many?* |
| Do you have any? Gold fillings Root canals | Implants | Bridges Crowns |

Do you have? Tooth pain Bleeding gums Gingivitis Chewing problems TMJ Oral thrush Swallowing problems Other, *please describe:*

Please list any previous injuries, surgeries, and hospitalizations; provide the date and your age, if known.



|  |  |
| --- | --- |
|  | *Please check the immunizations you have received.* |
| Immunization History Unknown (*skip this section if unknown*) | Comment |
| COVID Vaccine |  |
| Tetanus-Diphtheria Acellular Pertussis (Tdap) |  |
| Measles Mumps RubellaMMR (Measles, Mumps and Rubella) |  |
| Tuberculosis Skin Test Read Result: **OR**QuantiFERON-TB Gold Test Result: Chest X-ray BCG Vaccine |  |
| INH Treatment |  |  |
| Varicella (Chickenpox) |  |
| Hepatitis B |  |
| Meningococcal |  |
| Influenza |  |
| Polio |  |

|  |  |
| --- | --- |
| Medications & Supplements | *List all prescription medications and dietary supplements (vitamins, minerals, herbs/botanicals) you are currently taking.* |
| MEDICATION NAME | DOSE | FREQUENCY | REASON |
|  |  |  |  |
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Any other comments?

Have you ever had a nutrition consultation? Y *N If yes, date & and describe the outcome:*

Have you made any changes in your eating habits because of your health? Y N *Please describe:*

Do you currently follow a special diet or nutritional program? Y N *Please describe:*

Do you avoid any particular foods or beverages? Y N *If yes, what do you avoid and explain why?*

Any dietary accommodations for other family members? Y / N If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Height: | Current weight: | Weight 1 year ago: | Usual Weight: |
| Desired/goal weight: | Waist (inches): Hip (inches): |

Have you had any recent history of weight loss or weight gain? *If yes, please describe.*

Does your weight affect how you feel about yourself? Y N

Do you grocery shop? Y / N If no, who does the shopping?

Do you cook? Y / N If no, who does the cooking?

Number of meals eaten per day: 1 meal per day 2 meals per day 3 meals per day
Number of snacks eaten per day: None 1 2 3 > 3

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| What % of meals do you eat out | per week? | >75% | 50-75% | 25-50% | < 25% |
| Meal most often eaten out:Do you crave any foods? | Breakfast | Lunch | Dinner |  |  |

Are there special textures you prefer? Or avoid certain textures for a particular reason? *Please describe:*

What is your average daily water consumption (8-ounce glass)? <2 2-4 4-6 8 >

Check all the factors that apply to your eating habits and lifestyle:

Fast eater Love to eat Struggle with eating issues

Erratic eating patterns Love to cook Emotional eating

Eat too much Family members have different dietary needs

Eat fast food frequently

Late night eating Live or often eat alone Poor snack choices.

Rely on convenience items Time constraints Do not plan meals or menus Associate symptoms with eating Drink too much alcohol Travel frequently

Negative relationship with food Addicted to sugar/sweets Confused about nutrition

advice

Dislike healthy food Eat too many processed carbs (breads, pasta, chips)

Organic food is important to me

***Please note any additional comments about your eating habits:***

Do you engage in moderate cardiovascular physical activity for a minimum duration of 30 minutes at least 3 days a week? *For example: brisk walking, jogging, hiking, cardio exercise classes, cycling* Y N

|  |  |  |  |
| --- | --- | --- | --- |
| ACTIVITY | TYPE/INTENSITY*(low-moderate-high)* | # OF DAYS PER WEEK | DURATION *(minutes)* |
| Stretching/Yoga |  |  |  |
| Cardio/Aerobics |  |  |  |
| Strength Training |  |  |  |
| Sports or Leisure |  |  |  |

Note any problems that limit your physical activity:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Do you smoke? Y N | Do you chew tobacco?Y N | How many years? | Packs per day? | Secondhand smoke exposure?Y N |

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

Work Family Social Finances Health Other

How do you handle stress?

|  |  |
| --- | --- |
| Do you feel your life has meaning and purpose?Y N Unsure | Do you believe stress is presently reducing the quality of your life? Y N |
| Average number of hours you sleep per night during the week? <6 6-8 8-10 10+ | Average number of hours you sleep per night on weekends? <6 6-8 8-10 10+ |
| Trouble falling asleep? | Y | N | Rested upon waking? | Y | N |

Do you wake up during the night? Y N *If yes, how many times?*

How would you rate the overall quality of your sleep? 1 *Low* 2 3 4 5 *High*

(Skip if this does correlate with your goals)

Do you experience or have you been diagnosed with chemical sensitivities? Y N

*If yes, please describe:*

What is your occupation?

Are you exposed regularly to any of the following? *Check all that apply:*

Aluminum cookware Dry-cleaned clothes Pesticides

Auto exhaust/fumes Fertilizers Pet dander

Chemicals Heavy metals Other

Cigarette smoke Mold

Cosmetics: nail polish / hair dyes

/perfumes

Paint fumes

What do you think would make the most difference in your overall health?

In order to improve your health, how willing are you to: *Rate on a scale of 5 (very willing) to 1 (not willing)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Modify your current diet | 5 | 4 | 3 | 2 | 1 |
| Keep a record of everything you eat each day | 5 | 4 | 3 | 2 | 1 |
| Modify your lifestyle (e.g., work demands, sleep habits, exercise) | 5 | 4 | 3 | 2 | 1 |
| Engage in regular exercise/physical activity | 5 | 4 | 3 | 2 | 1 |
| Practice a daily relaxation technique | 5 | 4 | 3 | 2 | 1 |
| Take nutritional supplements as recommended | 5 | 4 | 3 | 2 | 1 |
| Have periodic lab tests to assess your progress | 5 | 4 | 3 | 2 | 1 |

Comments:

Complete this if you scored high in the Digestive/GI -DiphtheriaMySQ

Name Date

DIRECTIONS: This questionnaire asks you to assess how you have been feeling during the last four months. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, check all that apply to you.

|  |  |
| --- | --- |
| Section A |  |
| Indigestion, food repeats on you after you eat |  |
| Excessive burping, belching and/or bloating following meals |  |
| Stomach spasms and cramping during or after eating |  |
| Burning sensation in the lower part of your chest, especially when lying down or bending forward |  |
| Feel a sense of nausea when you eat |  |
| Generally constipated (or straining during bowel movements) |  |
| Skip meals or eat erratically because you have no appetite. |  |
| No urge to have a bowel movement |  |
| Stomach pain, burning and/or aching over a period of 1-4 hours after eating |  |
| Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache |  |
| Feel a sense of nausea when you eat |  |

|  |  |
| --- | --- |
| Three or more large bowel movements daily |  |
| No urge to have a bowel movement |  |
| An almost continual need to have a bowel movement |  |

*Please write a summary of any information that will be helpful to me regarding your health and medical history or in your own words, tell me your story.*

 Food Journal

|  |  |  |
| --- | --- | --- |
| DATE: | FOOD AND BEVERAGES | COMMENTS OR SYMPTOMS |
| Breakfast Time:  |  |  |
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| SnackTime:  |  |  |
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| LunchTime:  |  |  |
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| SnackTime:  |  |  |
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| DinnerTime:  |  |  |
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|  |  |
| Elimination | Time: Description: | Time: Description: | Time: Description: |
| DATE: | FOOD AND BEVERAGES | COMMENTS OR SYMPTOMS |
| Breakfast Time:  |  |  |
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| SnackTime:  |  |  |
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| LunchTime:  |  |  |
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| DinnerTime:  |  |  |
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| Elimination | Time: Description: | Time: Description: | Time: Description: |

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| --- | --- | --- |
| DATE: | FOOD AND BEVERAGES | COMMENTS OR SYMPTOMS |
| Breakfast Time:  |  |  |
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| SnackTime:  |  |  |
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| LunchTime:  |  |  |
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| DinnerTime:  |  |  |
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| Elimination | Time: Description: | Time: Description: | Time: Description: |

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