Nutritional Consultation Questionnaire

Please be advised that the information you provide here is only to get to know you better and understand your unique situation. All of this information will be kept confidential. You may personally drop this form off one week prior to your consultation or fax to 303-840-1319.

Personal Information

Name:____
Address:____
Phone:______________________________
E-mail______________________________
Height:____________ Weight:__________ Ideal Weight:__________

Medical History

Please list any medical conditions you have. Include date of onset and any procedures or treatments received for each condition. Also include copies of any labs done in the last year.

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List all prescription drugs you take:

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List all supplements you take including the dosages. If you can bring your supplement bottles to the consultation that is ideal:

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____

What illnesses is/was your father prone to?

____
____

What illnesses is/was your mother prone to?

____
____

Life Style

How many times do you exercise per week?___________

What type of exercise to you do and how frequently do you do it?

Weight lifting_________ Cardio_________ Yoga/Pilates__________ Other________
What is your intensity level during exercise?_______________

Grade your current state of health if 10 is excellent and 0 is poor.
1 2 3 4 5 6 7 8 9 10

Do you smoke/chew tobacco?________________

How many hours a week do you spend at work?______________

What are your sleeping habits?

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____

How many hours a day do you sit?_________________________

What things make it difficult for you to change your food intake, nutritional habits or physical activity? Examples: Time, Stress, Money, I don't like to exercise…

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Dietary Habits

Are you currently following a particular diet? If yes, please explain.

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Have you done food allergy or food sensitivity testing before? If yes, please explain including the results and whether or not it was helpful.

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____

How often do you eat fast food?____

List the restaurants you are most likely to eat at:

____
____

Which of the following beverages do you drink regularly?
Alcohol______
Milk______
Juice______
Soda/Pop______
Coffee______
Tea______
Water______
Sports Drinks______
Other______

Have you ever been on a diet? If yes, what diets have you tried?

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____

Do you have a history of bolemia or anorexia?_______________________________________

What would you like to gain from your nutritional consult?

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Anything else you would like to share?

____
____

Review of Systems

Please complete the following review of systems. Although some of the questions may no seem like they pertain to you, it helps me as a provider get a better understanding of your health and how I may best put a nutrition/supplement plan together for you or see a need for advanced testing. Please indicate the severity of your symptoms from 1-10, 10 being the worst next to each symptom.

Upper Gastrointestinal

Belching or gas shortly after eating		Do you feel like skipping breakfast	
Heartburn or Acid Reflux		Do you feel better if you don't eat	
Bloating shortly after eating		Are you sleepy after meals	
Bad breath		Fingernails which chip, peel, break	
Stomach upset by taking vitamins		Stomach pains or cramps	
Sense of excess fullness after eating		Do you use indigestion tablets	
Hurried eating habits		Diarrhea after meals	
Anemia unresponsive to Iron			

Liver and Gallbladder

Pain between shoulder blades		History of drug use	
Stomach upset with greasy foods		History of hepatitis	
Nausea		Long term use of prescriptions	
Light or clay colored stools		Sensitive to chemicals	
Gallbladder removed		Hurried eating habits	
Easily intoxicated		Chronic Fatigue or Fibromyalgia	

Small Intestine

Food allergies		Asthma, sinus infection, stuffy nose	
Bloating after eating		Brain fog or spacey feeling	
Specific foods that make you tired		Alternating constipation/diarrhea	
Airborne allergies		Hives	
Foods you could not give up			

Large Intestine

Coated tongue		IBS or Colitis	
Feel worse in moly or musty environment		Less than 1 bowel movement per day	
Fungus or yeast infections		Blood in stools	

Hard stools		Mucus in stools	
History of parasite infection		Excessive lower bowel gas/bloating	
Lower abdominal cramps		Bad breath	
Stools not well formed		Strong body odor	

Cardiovascular

High blood pressure		Overweight	
High cholesterol		Seldom exercise vigorously	
Family history of heart disease		Smoking, alcohol use or rec. drugs	

Immune System

Never get sick		Itchy skin or dermatitis	
Runny nose		Cysts, boils or rashes	
Mucus producing cough		Frequent colds or flu	
Frequent infections: ears, kidney, bladder, skin, sinus, lung…		History of Epstein Barr, Mono, Herpes, Shingles, Hepatitis or other viral infections.	

Men Only

Prostate problems		Waking at night to urinate	
Difficult to start or stop urine		Decreased sexual function	
Pain or burning when urinatin		Chronic constipation	

Women Only

Depression during periods		Breast fibroids	
Mood swings with periods		Vaginal discharge and itchiness	
Crave chocolate		Vaginal dryness	
Breast tenderness assoc. with cycle		Excess facial hair/body hair	
Excessive menstrual flow		Hot flashes	
Minimal menstrual flow		Endometriosis	
Ocassional skipped periods		Uterine fibroids	

Adrenals

Insomnia		Crave salty foods	
Slow starter in the morning		Muscles easily fatigued	
Feel wired or jittery with coffee		Chronic fatigue or freq. drowsiness	
Clench or grind teeth		Afternoon yawning	
Calm on the outside, troubled on the inside		Afternoon headache	
Dizziness when suddenly standing		Allergies and or hives	

Thyroid

Allergic to Iodine		Mentally sluggish	
Difficulty gaining weight		Easily fatigued, sleepy during the day	
Nervous, emotional, can't work under pressure		Sensitive to cold, poor circulation	
Inward trembling		Chronic constipation	
Flush easily		Difficulty losing weight	
Fast pulse at rest		Loss of lateral third of eyebrow	
Intolerance to high temperatures		Seasonal sadness	

Sugar

Awaken a few hours after falling asleep, hard to get back to sleep		Fatigue that is relieved by eating	
Crave sweets		Headaches if meals are skipped or delayed	
Eat desserts or sugary snacks		Irritable before meals	
Binge or uncontrolled eating		Shaky if meals are skipped	
Excessive appetite		Family members with diabetes	
Crave coffee or sugar in the afternoon		Frequent thirst	
Sleepy in the afternoon		Frequent urination	

Essential Fatty Acids

Suffer from PMS		Suffer from dry eyes	
History of infertility		Experience excessive thirst or sweating	
Poor memory or concentration		Dry flaky skin or dandruff	

Vitamin and Mineral Needs

Reactive to insect bites		Sore tongue	
Numbness tingling or itching in extremities		Pale skin	
Depressed		Muscles easily fatigued	
Worrier, apprehensive, anxious		Slow wound healing	
Easily exhausted		Bone loss	
Teeth grinding		MSG Sensitivity	
Wake up without remembering dreams		Take contraceptive pill	
Small bumps on back of arms		Sensitive to strong light at night	
Nosebleeds or tendency to bruise easily		Bleeding gums	
White spots on fingernails		Muscle cramps	
Strong foot odor		Decreased sense of smell or taste	

FOOD LOG

Name:___________________________________ Date:______________

TIME	FOOD AND DRINK DESCRIPTION	AMOUNT	SYMPTOMS