Nutrition Program Questionnaire

This questionnaire is designed to provide your functional medicine nutritionist with all the information necessary to create your customized nutrition and lifestyle program. Careful consideration of each of the following questions will enhance their efficiency and provide the most effective use of your scheduled consultation time. Please answer them as accurately as possible. Thank you.

Name: _____ Age: _____ Birthdate: _____
Address: _____
Mobile: _____ Email address: _____
Occupation: _____ Referred by: _____

Wellness Objective

What do you hope to achieve in your consultations with us? Examples: Increase energy; lose fat; improve mood; decrease stress.

_____
_____
_____
_____
_____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

Health Concerns

Please list your health concerns; how long you have had these for; and any medication taken to treat these.
Example: Depression; 5 Years; Effexor

Health Concern	*Duration*	*Medication*
1.		
2.		
3.		
4.		
5.		

Medication & Recreational Substances

Do you take medication other than those listed above? _____
Have you had prolonged use of Advil, Aleve, Motrin, Asprin or Tylenol? _____
Have you had prolonged use of Acid Blocking Drugs such as Zantac, Prilosec, Prevacid? _____
Have you taken antibiotics more than 2 times/year? _____
Have you used steroids (prednisone, nasal allergy inhalers) in the past? _____
Do you use recreational drugs? If so, state what and frequency: _____

Heredity Profile

What illness is/was your father prone to? _____
What illness is/was your mother prone to? _____
If applicable, what illness is/are your siblings prone to? _____
Do you have children? If so, state age: _____

Nutrition Program Questionnaire

Medical History

Diseases/Diagnosis/Conditions
Check appropriate box and provide date of onset ✓ = Ongoing Condition ✓ = Past Condition

Gastrointestinal
- ○ ○ Irritable Bowel Syndrome _____
- ○ ○ Inflammatory Bowel Disease _____
- ○ ○ Crohn's _____
- ○ ○ Ulcerative Colitis _____
- ○ ○ Gastritis or Peptic Ulcer Disease _____
- ○ ○ GERD (reflux) _____
- ○ ○ Celiac Disease _____
- ○ ○ Other _____

Cardiovascular
- ○ ○ Heart Attack _____
- ○ ○ Other Heart Disease _____
- ○ ○ Stroke _____
- ○ ○ Elevated Cholesterol _____
- ○ ○ Arrythmia (irregular heart rate) _____
- ○ ○ Hypertension (high blood pressure) _____
- ○ ○ Rheumatic Fever _____
- ○ ○ Mitral Valve Prolapse _____
- ○ ○ Other _____

Metabolic/Endocrine
- ○ ○ Type 1 Diabetes _____
- ○ ○ Type 2 Diabetes _____
- ○ ○ Hypoglycemia _____
- ○ ○ Metabolic Syndrome _____
- ○ ○ Hypothyroidism (low thyroid) _____
- ○ ○ Hyperthyroidism (overactive thyroid) _____
- ○ ○ Polycystic Ovarian Syndrome (PCOS) _____
- ○ ○ Infertility _____
- ○ ○ Weight Gain _____
- ○ ○ Weight Loss _____
- ○ ○ Frequent Weight Fluctuations _____
- ○ ○ Other _____

Musculoskeletal/Pain
- ○ ○ Osteoarthritis _____
- ○ ○ Fibromyalgia _____
- ○ ○ Chronic Pain _____
- ○ ○ Other _____

Neurologic/Mood
- ○ ○ Depression _____
- ○ ○ Anxiety _____
- ○ ○ Bipolar Disorder _____
- ○ ○ Schizophrenia _____
- ○ ○ Headaches _____
- ○ ○ Migraines _____
- ○ ○ ADD/ADHD _____
- ○ ○ Mild Cognitive Impairment _____
- ○ ○ Memory Problems _____
- ○ ○ Parkinson's Disease _____
- ○ ○ Multiple Sclerosis _____
- ○ ○ Seizures _____
- ○ ○ Other Neurological Problems _____

Cancer
- ○ ○ Lung Cancer _____
- ○ ○ Breast Cancer _____
- ○ ○ Colon Cancer _____
- ○ ○ Ovarian Cancer _____
- ○ ○ Prostate Cancer _____
- ○ ○ Skin Cancer _____
- ○ ○ Other _____

Genital and Urinary Systems
- ○ ○ Kidney Stones _____
- ○ ○ Gout _____
- ○ ○ Interstitial Cystitis _____
- ○ ○ Frequent Urinary Tract Infections _____
- ○ ○ Frequent Yeast Infections _____
- ○ ○ Erectile Dysfunction or Sexual Dysfunction _____
- ○ ○ Other _____

Inflammatory/Autoimmune
- ○ ○ Chronic Fatigue Syndrome _____
- ○ ○ Rheumatoid Arthritis _____
- ○ ○ Lupus SLE _____
- ○ ○ Herpes _____
- ○ ○ Poor Immune Function _____
- ○ ○ Food Allergies _____
- ○ ○ Environmental Allergies _____
- ○ ○ Multiple Chemical Sensitivities _____
- ○ ○ Latex Allergy _____
- ○ ○ Other _____

Eating Disorders
- ○ ○ Bulimia _____
- ○ ○ Anorexia _____
- ○ ○ Binge Eating Disorder _____
- ○ ○ Night Eating Syndrome _____
- ○ ○ Eating Disorder (non-specific) _____
- ○ ○ Other _____

Respiratory Diseases
- ○ ○ Asthma _____
- ○ ○ Chronic Sinusitis _____
- ○ ○ Bronchitis _____
- ○ ○ Emphysema _____
- ○ ○ Pneumonia _____
- ○ ○ Sleep Apnea _____
- ○ ○ Other _____

Skin Diseases
- ○ ○ Eczema _____
- ○ ○ Psoriasis _____
- ○ ○ Acne _____
- ○ ○ Other _____

Nutrition Program Questionnaire

Symptom Analysis

Please underline all of the symptoms that you have experienced in the last 12 months. Each section pertains to a specific nutritional deficiency, so please underline the symptom that you experience every time it appears.

Vitamin A
Acne
Dandruff
Diarrhea
Dry flaky skin
Frequent colds
Frequent infections
Mouth ulcers
Poor night vision
Thrush or cystitis

Vitamin C
Bleeding or tender gums
Easy bruising
Frequent colds
Frequent infections
Lack of energy
Nose bleeds
Red pimples on skin
Slow wound healing

Vitamin D
Backache
Excessive sweating
Hair loss
Joint pain or stiffness
Lack of energy
Muscle cramps
Rheumatism or arthritis
Tooth decay

Vitamin E
Easy bruising
Exhaustion after light exercise
Infertility
Lack of sex drive
Loss of muscle tone
Slow wound healing
Varicose veins

Vitamin B1
Constipation
Eye pain
Irritability
Poor concentration
Poor memory
Prickly legs
Rapid heart beat
Stomach Pains
Tender muscles
Tingling hands

Vitamin B2
Burning or gritty eyes
Cataracts
Cracked lips
Dull or oily hair
Eczema, dermatitis or psoriasis
Sensitivity to bright lights
Sore tongue
Split nails

Vitamin B3
Acne
Anxiety or tension
Bleeding or tender gums
Depression
Diarrhea
Headaches or migraines
Insomnia
Irritability
Lack of energy
Poor memory

Vitamin B5
Anxiety or tension
Apathy
Burning feet or tender heels
Exhaustion after light exercise
Lack of energy
Muscle tremors or cramps
Nausea or vomiting
Poor concentration
Teeth grinding

Vitamin B6
Depression or nervousness
Flaky skin
Infrequent dream recall
Irritability
Lack of energy
Muscle tremors or cramps
Tingling hands
Water retention

Vitamin B12
Anxiety or tension
Constipation
Eczema, dermatitis or psoriasis
Irritability
Lack of energy
Mouth over-sensitive to hot/cold
Pale skin
Poor hair condition
Sore/reddened tongue
Tender or sore muscles

Folic Acid
Anxiety or tension
Cracked lips
Depression
Eczema, dermatitis or psoriasis
Lack of energy
Poor appetite
Poor memory
Prematurely graying hair
Stomach pains

Biotin
Depression
Dry skin
Eczema, dermatitis or psoriasis
Insomnia
Nausea
Poor hair condition
Poor appetite
Prematurely graying hair
Tender or sore muscle

Essential Fats
Diarrhea
Dry eyes
Dry, rough skin
Excessive thirst
Frequent infections
Infertility
Loss of hair or dandruff
PMS or breast pain
Poor memory
Poor wound healing

Calcium
Arthritis or joint pain
High blood pressure
Insomnia
Muscle cramps or tremors
Nervousness
Tooth decay

Magnesium
Anxiety
Constipation
Depression
Fits or convulsions
High blood pressure
Hyperactivity
Insomnia
Irregular heart beat
Muscle tremors or spasms
Muscle weakness
Nervousness

Zinc
Acne or greasy skin
Frequent infections
Low fertility
Pale skin
Poor appetite
Poor sense of taste or smell
Stretch marks
Tendency towards depression
White marks on two or more fingernails

Iodine
Cold hands or sensitivity to the cold
Easily gain weight
Fatigue
Low energy

Iron
Fatigue
Heavy periods
Loss of appetite
Low energy
Nausea
Pale skin
Sore tongue

Selenium
Arthritic pain
Cataracts
Family history of cancer
Frequent infections
High blood pressure

Chromium
'Addicted' to sweet foods
Cold hands
Dizziness or irritability after 6 hours without food
Excessive or cold sweats
Excessive thirst
Need for excessive sleep or drowsiness during day
Need for frequent meals

Manganese
Childhood 'growing pains'
Dizziness or poor sense of balance
Fits or convulsions
Muscle twitches

Nutrition Program Questionnaire

Lifestyle Analysis

Please check or underline where appropriate.

Digestion Profile

- ○ Do you chew your food thoroughly?
- ○ Do you sometimes suffer from bad breath?
- ○ Are you prone to stomach upsets?
- ○ Do you feel nauseous after taking supplements?
- ○ Do you often get a burning sensation in your stomach?
- ○ Do you find it difficult to digest fatty foods?
- ○ Do you occasionally use indigestion tablets?
- ○ Do you experience anal irritation?
- ○ Do you experience intestinal gas?
- ○ Do you have a daily bowel movement?

Gastrointestinal Flora Profile

- ○ Are you prone to thrush or cystitis?
- ○ Are you prone to athlete's foot or fungal infections?
- ○ Are you sensitive to chemical fumes, perfume and smoke?
- ○ Do you crave sweet foods, bread or alcohol?
- ○ Do you experience abdominal bloating after meals?
- ○ Do you commonly suffer from flatulence?
- ○ Do you feel like you digest your food well?
- _____ How often have you traveled to Mexico, South America and/or Asia in the past 10 years?

Toxin Profile

- ○ Do you generally eat organic fruit & vegetables?
- ○ Do you generally eat organic meats & dairy products?
- ○ Do you have silver mercury fillings?
- ○ Do you generally drink filtered tap water?
- ○ Do you drink from plastic water bottles?
- ○ Do you heat food in plastic containers in the microwave?
- ○ Do you use teflon or aluminum cooking pans?
- ○ Do you generally use eco-friendly cleaning products?
- ○ Do you smoke more than 3 cigarettes per day?
- ○ Do you exercise (jog, cycle, play sports) by busy roads?
- ○ Does your house smell like mold when you first enter it?
- ○ Have you ever lived in a moldy house?
- _____ How often do you eat tuna per week?

Glucose Tolerance Profile

- ○ Are you rarely alert within 20 minutes of waking?
- ○ Do you need coffee or tea to get you going in the morning?
- ○ Do you have coffee or tea at regular intervals during the day?
- ○ Do you get sugar cravings in the afternoon?
- ○ 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?
- ○ Is your energy less than it used to be?
- ○ Do you frequently wake up in the middle of the night?

Immune Profile

- ○ Do you get more than three colds a year?
- ○ Do you often find it hard to shift an infection or cold?
- ○ Have you ever had any growths or lumps biopsied?
- ○ Do you have eczema, asthma or arthritis?
- ○ Do you suffer from hay-fever?
- ○ Have you had a major personal loss in the past five years?

Thyroid Profile

- ○ Do you suffer from extreme fatigue or lethargy?
- ○ Are you sensitive to the cold?
- ○ Do you have cold extremities?
- ○ Have you experienced major weight gain or loss?
- ○ Do you have tenderness in your sternum?
- ○ Do you experience mood swings, anxiety or panic?
- ○ Do you have a tendency to cry easily?
- ○ Do you have cracked heels?

Sleep Profile

- ○ Do you have trouble falling asleep?
- ○ Do you have difficulty staying asleep?
- ○ Do you feel rested upon waking?
- ○ Do you suffer from sleep apnea or snoring?
- ○ Do you take anything to help you sleep?
- _____ State the average number of hours of sleep per night
- _____ State the time you typically get to bed

Exercise Profile

- ○ Do you regularly play sport (tennis, squash etc)?
- ○ Do you work-out with a trainer?
- ○ Do you use exercise as a stress release?
- _____ How often do you exercise per week?
- _____ How long do you typically exercise for?
- _____ How frequently do you take a yoga class?

Allergy Profile

Do you suffer from any of the following? Please check.

- ○ Asthma
- ○ Bloating
- ○ Canker Sores
- ○ Dermatitis
- ○ Eczema
- ○ Facial Puffiness
- ○ Hay Fever
- ○ Irritable Bowel Syndrome
- ○ Migraines
- ○ Nasal Problems

Do you have any allergies? ○ Yes ○ No

If so, what? _____

_____

State type of reaction: _____

_____

Have you been tested? _____

Nutrition Program Questionnaire

Lifestyle Analysis (continued)

Please check or underline where appropriate.

Psychosocial Profile

- ○ Are you happy?
- ○ Do you feel your life has meaning and purpose?
- ○ Do you believe that stress is reducing your quality of life?
- ○ Do you like the work you do?
- ○ Have you experienced a major loss in your life?
- ○ Would you describe your childhood experience as happy?
- ○ Do you spend the majority of your time and money to fulfill responsibilities and obligations?

Stress Profile

- ○ Have you ever sought counseling?
- ○ Are you currently in therapy?
- ○ Do you feel you can easily handle the amount of stress in your life?

Please rate your daily stressors on a scale of:
1 (no stress) - 10 (high stress)

_____ Work _____ Family
_____ Social _____ Finances
_____ Health _____ Other

Do you actively engage in stress management techniques? ○ Yes ○ No

If yes, please state what: _____

_____

Additional questions for women only:

- ○ Are you pregnant?
  If so, how many weeks? _____
- ○ Are you trying to become pregnant?
- ○ Have you ever miscarried?
- ○ Do you use birth control pills or have an IUD?
- ○ Are your periods regular?

Are you peri-menopausal? ○ Yes ○ No
Are you post-menopausal? ○ Yes ○ No
Date: _____

Do you suffer from any of the following?
Please check.

- ○ Abdominal Pain ○ Back Pain
- ○ Breast Tenderness ○ Depression
- ○ Emotional Outbursts ○ Headaches
- ○ Irritability ○ Pre-Menstrual Bloating
- ○ Tiredness

Readiness Assessment

Rate on a scale of: 1 (not willing) - 5 (very willing)

_____ Modify your diet
_____ Take several nutritional supplements each day
_____ Keep a record of what you eat each day
_____ Modify your lifestyle (e.g., work demands, sleep habits)
_____ Practice a relaxation technique
_____ Engage in regular exercise
_____ Have periodic lab tests to assess your progress
_____ How confident are you in your ability to organize and follow through on the above health related activities?
_____ How supportive are the people in your household to the implementation of the above changes?

If you are not confident of your ability to organize and follow through, what aspects of yourself or your life do you believe question your capacity to fully engage in the above activities?: _____

_____

_____

_____

How would you like to be rewarded when you reach your wellness goals?: _____

_____

_____

_____

_____

Nutritional Supplements

What nutritional supplements do you take on a daily/regular basis. Please state brand.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Nutrition Program Questionnaire

Nutrition History

Have you seen a nutritionist before? If so, please state when: _____

Do you currently follow a special diet or nutritional program? ○ Yes ○ No

Check all that apply:

○ Low Fat ○ Low Carbohydrate ○ High Protein ○ Low Sodium ○ Diabetic ○ No Dairy ○ No Wheat ○ Gluten Restricted

○ Vegetarian ○ Vegan ○ Low Sugar ○ Other: _____

Usual Weight Range +/-5lbs _____

Highest Adult Weight _____

Desired Weight Range +/-5lbs _____

Weight Fluctuations (> 10lbs) ○ Yes ○ No

How often do you weigh yourself?

○ Daily ○ Weekly ○ Monthly ○ Rarely ○ Never

Diet Analysis

Please fill in the number of times you eat the referred food or drink or check as required.

_____ How often do you eat red meat per week?
_____ How often do you eat poultry per week?
_____ How often do you eat salmon, tuna or halibut per week?
_____ How often do you eat fries per week?
_____ How often do you eat chocolate per week?
_____ How often do you eat cupcakes, muffins, cookies per week?
_____ How often do you eat bread or bagels per week?
_____ How often do you drink soda per week?
_____ How many glasses of milk do you drink in a week?
_____ How many cups of coffee do you drink per day?
_____ How many cups of tea do you drink per day?
_____ How many tsps of sugar do you add to your drinks each day?
_____ Do you normally eat white flour, pasta or rice?
_____ How often do you buy take-out?
_____ What percentage of your diet is raw fruit and vegetables?
_____ Do you normally wash fruit and vegetables before eating?
_____ How many glasses of water do you drink per day?
_____ How many glasses of alcohol do you drink per week?

What is your usual alcoholic drink? _____

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

_____

_____

_____

Do you have any cultural or religious influences that affect your food choices?

_____

_____

_____

Are there any foods you won't eat?

_____

_____

_____

Eating Habits

Please check all the factors that apply:

○ Confused about nutrition
○ Consume food quickly
○ Do not plan meals or menus
○ Don't care to cook
○ Eat because I have to
○ Eat too much
○ Eat too little under stress
○ Eat too much under stress
○ Emotional eater
○ Erratic eating pattern
○ Job requires frequent dining out
○ Late night eating
○ Negative relationship with food
○ Non-availability of healthy foods
○ Poor snack choices
○ Reliance on convenience foods
○ Time constrained
○ Travel frequently
○ Want to cook simple meals

How many times per week do you prepare meals at home?

_____ Breakfast
_____ Lunch
_____ Dinner

Do you read food labels? ○ Yes ○ No

Do you cook? ○ Yes ○ No

Do you grocery shop? ○ Yes ○ No

Where do you grocery shop?

_____

_____

_____

_____

_____

_____

Nutrition Program Questionnaire

Food Diary

Write down all the foods and drinks consumed over the next three days. Please state the time consumed. Add as much information as possible including quantities eaten, brand names and whether the food is fresh, packaged, refined or natural.

Day 1

Wake Up Time: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Day 2

Wake Up Time: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Day 3

Wake Up Time: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Representative Day

Wake Up Time: _____

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____