

# Nutritional Assessment Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birth Date: \_\_\_\_\_

Gender: \_\_\_\_\_

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

<b>Notes:</b>
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## PART I Read the following questions and circle the number that applies:

KEY:      0 = Do not consume or use                              2 = Consume or use weekly  
              1 = Consume or use 2 to 3 times monthly            3 = Consume or use daily

### DIET

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- |   |                                  |   |
|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol                        | 7. 0 1 2 3 Cigars/pipes          | 14. 0 1 Radiation exposure (0=no, 1=yes)  |
| 2. 0 1 2 3 Artificial sweeteners          | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods     |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods            | 16. 0 1 2 3 Vitamins and minerals         |
| 4. 0 1 2 3 Carbonated beverages           | 10. 0 1 2 3 Fried foods          | 17. 0 1 2 3 Water, distilled              |
| 5. 0 1 2 3 Chewing tobacco                | 11. 0 1 2 3 Luncheon meats       | 18. 0 1 2 3 Water, tap                    |
| 6. 0 1 2 3 Cigarettes                     | 12. 0 1 2 3 Margarine            | 19. 0 1 2 3 Water, well                   |
|   | 13. 0 1 2 3 Milk products        | 20. 0 1 2 3 Diet often for weight control |

### LIFESTYLE

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

### MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0 = no, 1 = yes)

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- |  |   |
|--|---|
| 25. 0 1 Antacids                                   | 39. 0 1 Diuretics   |
| 26. 0 1 Antianxiety medications                    | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics                                | 41. 0 1 Estrogen or progesterone (natural)                      |
| 28. 0 1 Anticonvulsants                            | 42. 0 1 Heart medications                                       |
| 29. 0 1 Antidepressants                            | 43. 0 1 High blood pressure medications                         |
| 30. 0 1 Antifungals                                | 44. 0 1 Laxatives   |
| 31. 0 1 Aspirin/Ibuprofen                          | 45. 0 1 Recreational drugs                                      |
| 32. 0 1 Asthma inhalers                            | 46. 0 1 Relaxants/Sleeping pills                                |
| 33. 0 1 Beta blockers                              | 47. 0 1 Testosterone (natural or prescription)                  |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication                                      |
| 35. 0 1 Chemotherapy                               | 49. 0 1 Acetaminophen (Tylenol)                                 |
| 36. 0 1 Cholesterol lowering medications           | 50. 0 1 Ulcer medications                                       |
| 37. 0 1 Cortisone/steroids                         | 51. 0 1 Sildenafil citrate (Viagra)                             |
| 38. 0 1 Diabetic medications/insulin               |   |

## PART II (See key at bottom of page)

### Section 1

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- |   |  |
|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating        | 61. 0 1 2 3 Feel like skipping breakfast           |
| 53. 0 1 2 3 Heartburn or acid reflux                            | 62. 0 1 2 3 Feel better if you don't eat           |
| 54. 0 1 2 3 Bloating within one hour after eating               | 63. 0 1 2 3 Sleepy after meals                     |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis)                              | 65. 0 1 2 3 Anemia unresponsive to iron            |
| 57. 0 1 2 3 Loss of taste for meat                              | 66. 0 1 2 3 Stomach pains or cramps                |
| 58. 0 1 2 3 Sweat has a strong odor                             | 67. 0 1 2 3 Diarrhea, chronic                      |
| 59. 0 1 2 3 Stomach upset by taking vitamins                    | 68. 0 1 2 3 Diarrhea shortly after meals           |
| 60. 0 1 2 3 Sense of excess fullness after meals                | 69. 0 1 2 3 Black or tarry colored stools          |
|   | 70. 0 1 2 3 Undigested food in stool               |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

**Section 2**

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- 71. 0 1 2 3 Pain between shoulder blades
- 72. 0 1 2 3 Stomach upset by greasy foods
- 73. 0 1 2 3 Greasy or shiny stools
- 74. 0 1 2 3 Nausea
- 75. 0 1 2 3 Sea, car, airplane or motion sickness
- 76. 0 1 History of morning sickness (0 = no, 1 = yes)
- 77. 0 1 2 3 Light or clay colored stools
- 78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
- 79. 0 1 2 3 Headache over eyes
- 80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
- 81. 0 1 Gallbladder removed (0=no, 1=yes)
- 82. 0 1 2 3 Bitter taste in mouth, especially after meals
- 83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
- 84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
- 85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
- 86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
- 87. 0 1 Recovering alcoholic (0=no, 1=yes)
- 88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
- 89. 0 1 History of hepatitis (0=no, 1=yes)
- 90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
- 91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
- 92. 0 1 2 3 Sensitive to tobacco smoke
- 93. 0 1 2 3 Exposure to diesel fumes
- 94. 0 1 2 3 Pain under right side of rib cage
- 95. 0 1 2 3 Hemorrhoids or varicose veins
- 96. 0 1 2 3 Nutrasweet (aspartame) consumption
- 97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
- 98. 0 1 2 3 Chronic fatigue or Fibromyalgia

**Section 3**

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- 99. 0 1 2 3 Food allergies
- 100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
- 101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
- 102. 0 1 2 3 Pulse speeds after eating
- 103. 0 1 2 3 Airborne allergies
- 104. 0 1 2 3 Experience hives
- 105. 0 1 2 3 Sinus congestion, "stuffy head"
- 106. 0 1 2 3 Crave bread or noodles
- 107. 0 1 2 3 Alternating constipation and diarrhea
- 108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currenty mild condition, 3=severe)
- 109. 0 1 2 3 Wheat or grain sensitivity
- 110. 0 1 2 3 Dairy sensitivity
- 111. 0 1 Are there foods you could not give up (0=no, 1=yes)
- 112. 0 1 2 3 Asthma, sinus infections, stuffy nose
- 113. 0 1 2 3 Bizarre vivid dreams, nightmares
- 114. 0 1 2 3 Use over-the-counter pain medications
- 115. 0 1 2 3 Feel spacey or unreal

**Section 4**

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- 116. 0 1 2 3 Anus itches
- 117. 0 1 2 3 Coated tongue
- 118. 0 1 2 3 Feel worse in moldy or musty place
- 119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
- 120. 0 1 2 3 Fungus or yeast infections
- 121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
- 122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
- 123. 0 1 2 3 Stools hard or difficult to pass
- 124. 0 1 History of parasites (0=no, 1=yes)
- 125. 0 1 2 3 Less than one bowel movement per day
- 126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
- 127. 0 1 2 3 Stools are not well formed (loose)
- 128. 0 1 2 3 Irritable bowel or mucus colitis
- 129. 0 1 2 3 Blood in stool
- 130. 0 1 2 3 Mucus in stool
- 131. 0 1 2 3 Excessive foul smelling lower bowel gas
- 132. 0 1 2 3 Bad breath or strong body odors
- 133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
- 134. 0 1 2 3 Cramping in lower abdominal region
- 135. 0 1 2 3 Dark circles under eyes

**Section 5**

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- 136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
- 137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
- 138. 0 1 History of stress fracture (0=no, 1=yes)
- 139. 0 1 2 3 Bone loss (reduced density on bone scan)
- 140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
- 141. 0 1 2 3 Calf, foot or toe cramps at rest
- 142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
- 143. 0 1 2 3 Frequent fevers
- 144. 0 1 2 3 Frequent skin rashes and/or hives
- 145. 0 1 Herniated disc (0=no, 1=yes)
- 146. 0 1 2 3 Excessively flexible joints, "double jointed"
- 147. 0 1 2 3 Joints pop or click
- 148. 0 1 2 3 Pain or swelling in joints
- 149. 0 1 2 3 Bursitis or tendonitis
- 150. 0 1 History of bone spurs (0=no, 1=yes)
- 151. 0 1 2 3 Morning stiffness
- 152. 0 1 2 3 Nausea with vomiting
- 153. 0 1 2 3 Crave chocolate
- 154. 0 1 2 3 Feet have a strong odor
- 155. 0 1 2 3 History of anemia
- 156. 0 1 2 3 Whites of eyes (sclera) blue tinted
- 157. 0 1 2 3 Hoarseness
- 158. 0 1 2 3 Difficulty swallowing
- 159. 0 1 2 3 Lump in throat
- 160. 0 1 2 3 Dry mouth, eyes and/or nose
- 161. 0 1 2 3 Gag easily
- 162. 0 1 2 3 White spots on fingernails
- 163. 0 1 2 3 Cuts heal slowly and/or scar easily
- 164. 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)	2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)
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**Section 6**

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- 165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
- 166. 0 1 2 3 Crave fatty or greasy foods
- 167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
- 168. 0 1 2 3 Tension headaches at base of skull
- 169. 0 1 2 3 Headaches when out in the hot sun
- 170. 0 1 2 3 Sunburn easily or suffer sun poisoning
- 171. 0 1 2 3 Muscles easily fatigued
- 172. 0 1 2 3 Dry flaky skin or dandruff

**Section 7**

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- 173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
- 174. 0 1 2 3 Crave sweets
- 175. 0 1 2 3 Binge or uncontrolled eating
- 176. 0 1 2 3 Excessive appetite
- 177. 0 1 2 3 Crave coffee or sugar in the afternoon
- 178. 0 1 2 3 Sleepy in afternoon
- 179. 0 1 2 3 Fatigue that is relieved by eating
- 180. 0 1 2 3 Headache if meals are skipped or delayed
- 181. 0 1 2 3 Irritable before meals
- 182. 0 1 2 3 Shaky if meals delayed
- 183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
- 184. 0 1 2 3 Frequent thirst
- 185. 0 1 2 3 Frequent urination

**Section 8**

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- 186. 0 1 2 3 Muscles become easily fatigued
- 187. 0 1 2 3 Feel exhausted or sore after moderate exercise
- 188. 0 1 2 3 Vulnerable to insect bites
- 189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
- 190. 0 1 2 3 Enlarged heart or congestive heart failure
- 191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
- 192. 0 1 2 3 Ringing in the ears (Tinnitus)
- 193. 0 1 2 3 Numbness, tingling or itching in hands and feet
- 194. 0 1 2 3 Depressed
- 195. 0 1 2 3 Fear of impending doom
- 196. 0 1 2 3 Worrier, apprehensive, anxious
- 197. 0 1 2 3 Nervous or agitated
- 198. 0 1 2 3 Feelings of insecurity
- 199. 0 1 2 3 Heart races
- 200. 0 1 2 3 Can hear heart beat on pillow at night
- 201. 0 1 2 3 Whole body or limb jerk as falling asleep
- 202. 0 1 2 3 Night sweats
- 203. 0 1 2 3 Restless leg syndrome
- 204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
- 205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
- 206. 0 1 2 3 Polyps or warts
- 207. 0 1 2 3 MSG sensitivity
- 208. 0 1 2 3 Wake up without remembering dreams
- 209. 0 1 2 3 Small bumps on back of arms
- 210. 0 1 2 3 Strong light at night irritates eyes
- 211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
- 212. 0 1 2 3 Bleeding gums especially when brushing teeth

**Section 9**

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- 213. 0 1 2 3 Tend to be a "night person"
- 214. 0 1 2 3 Difficulty falling asleep
- 215. 0 1 2 3 Slow starter in the morning
- 216. 0 1 2 3 Tend to be keyed up, trouble calming down
- 217. 0 1 2 3 Blood pressure above 120/80
- 218. 0 1 2 3 Headache after exercising
- 219. 0 1 2 3 Feeling wired or jittery after drinking coffee
- 220. 0 1 2 3 Clench or grind teeth
- 221. 0 1 2 3 Calm on the outside, troubled on the inside
- 222. 0 1 2 3 Chronic low back pain, worse with fatigue
- 223. 0 1 2 3 Become dizzy when standing up suddenly
- 224. 0 1 2 3 Difficulty maintaining manipulative correction
- 225. 0 1 2 3 Pain after manipulative correction
- 226. 0 1 2 3 Arthritic tendencies
- 227. 0 1 2 3 Crave salty foods
- 228. 0 1 2 3 Salt foods before tasting
- 229. 0 1 2 3 Perspire easily
- 230. 0 1 2 3 Chronic fatigue, or get drowsy often
- 231. 0 1 2 3 Afternoon yawning
- 232. 0 1 2 3 Afternoon headache
- 233. 0 1 2 3 Asthma, wheezing or difficulty breathing
- 234. 0 1 2 3 Pain on the medial or inner side of the knee
- 235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
- 236. 0 1 2 3 Tendency to need sunglasses
- 237. 0 1 2 3 Allergies and/or hives
- 238. 0 1 2 3 Weakness, dizziness

**Section 10**

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- 239. 0 1 Height over 6' 6" (0=no, 1=yes)
- 240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
- 241. 0 1 2 3 Increased libido
- 242. 0 1 2 3 Splitting type headache
- 243. 0 1 2 3 Memory failing
- 244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
- 245. 0 1 Height under 4' 10" (0=no, 1=yes)
- 246. 0 1 2 3 Decreased libido
- 247. 0 1 2 3 Excessive thirst
- 248. 0 1 2 3 Weight gain around hips or waist
- 249. 0 1 2 3 Menstrual disorders
- 250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
- 251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)	2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)
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**Section 11**

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- 252. 0 1 2 3 Sensitive/allergic to iodine
- 253. 0 1 2 3 Difficulty gaining weight, even with large appetite
- 254. 0 1 2 3 Nervous, emotional, can't work under pressure
- 255. 0 1 2 3 Inward trembling
- 256. 0 1 2 3 Flush easily
- 257. 0 1 2 3 Fast pulse at rest
- 258. 0 1 2 3 Intolerance to high temperatures
- 259. 0 1 2 3 Difficulty losing weight
- 260. 0 1 2 3 Mentally sluggish, reduced initiative
- 261. 0 1 2 3 Easily fatigued, sleepy during the day
- 262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
- 263. 0 1 2 3 Constipation, chronic
- 264. 0 1 2 3 Excessive hair loss and/or coarse hair
- 265. 0 1 2 3 Morning headaches, wear off during the day
- 266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
- 267. 0 1 2 3 Seasonal sadness

**Section 12 – Men Only**

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- 268. 0 1 2 3 Prostate problems
- 269. 0 1 2 3 Difficulty with urination, dribbling
- 270. 0 1 2 3 Difficult to start and stop urine stream
- 271. 0 1 2 3 Pain or burning with urination
- 272. 0 1 2 3 Waking to urinate at night
- 273. 0 1 2 3 Interruption of stream during urination
- 274. 0 1 2 3 Pain on inside of legs or heels
- 275. 0 1 2 3 Feeling of incomplete bowel evacuation
- 276. 0 1 2 3 Decreased sexual function

**Section 13 – Women Only**

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- 277. 0 1 2 3 Depression during periods
- 278. 0 1 2 3 Mood swings associated with periods (PMS)
- 279. 0 1 2 3 Crave chocolate around periods
- 280. 0 1 2 3 Breast tenderness associated with cycle
- 281. 0 1 2 3 Excessive menstrual flow
- 282. 0 1 2 3 Scanty blood flow during periods
- 283. 0 1 2 3 Occasional skipped periods
- 284. 0 1 2 3 Variations in menstrual cycles
- 285. 0 1 2 3 Endometriosis
- 286. 0 1 2 3 Uterine fibroids
- 287. 0 1 2 3 Breast fibroids, benign masses
- 288. 0 1 2 3 Painful intercourse (dysparenia)
- 289. 0 1 2 3 Vaginal discharge
- 290. 0 1 2 3 Vaginal dryness
- 291. 0 1 2 3 Vaginal itchiness
- 292. 0 1 2 3 Gain weight around hips, thighs and buttocks
- 293. 0 1 2 3 Excess facial or body hair
- 294. 0 1 2 3 Hot flashes
- 295. 0 1 2 3 Night sweats (in menopausal females)
- 296. 0 1 2 3 Thinning skin

**Section 14**

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- 297. 0 1 2 3 Aware of heavy and/or irregular breathing
- 298. 0 1 2 3 Discomfort at high altitudes
- 299. 0 1 2 3 "Air hunger" or sigh frequently
- 300. 0 1 2 3 Compelled to open windows in a closed room
- 301. 0 1 2 3 Shortness of breath with moderate exertion
- 302. 0 1 2 3 Ankles swell, especially at end of day
- 303. 0 1 2 3 Cough at night
- 304. 0 1 2 3 Blush or face turns red for no reason
- 305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
- 306. 0 1 2 3 Muscle cramps with exertion

**Section 15**

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- 307. 0 1 2 3 Pain in mid-back region
- 308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
- 309. 0 1 History of kidney stones (0=no, 1=yes)
- 310. 0 1 2 3 Cloudy, bloody or darkened urine
- 311. 0 1 2 3 Urine has a strong odor

**Section 16**

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- 312. 0 1 2 3 Runny or drippy nose
- 313. 0 1 2 3 Catch colds at the beginning of winter
- 314. 0 1 2 3 Mucus producing cough
- 315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
- 316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
- 317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
- 318. 0 1 2 3 Acne (adult)
- 319. 0 1 2 3 Itchy skin (Dermatitis)
- 320. 0 1 2 3 Cysts, boils, rashes
- 321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)