



## Nutrition Program Questionnaire

*PRIVATE AND CONFIDENTIAL*

This questionnaire is designed to provide your nutritionist with all the information necessary to build an individual nutritional program specifically tailored to your needs. Please answer the questions as accurately as possible.

### Personal Profile

Date \_\_\_\_\_

Name

\_\_\_\_\_

Address

\_\_\_\_\_

\_\_\_\_\_

Best Telephone Number

\_\_\_\_\_

Occupation

\_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_

Date of Birth:

Email Address \_\_\_\_\_

# Nutrition Program Questionnaire

## Health Profile

List all health issues you would like to clear up, and indicate how long you have had these symptoms.  
e.g.: Headaches / 5 years (Continue on a separate sheet if needed)

### Health Issue / Duration

1 \_\_\_\_\_

2 \_\_\_\_\_

3 \_\_\_\_\_

4 \_\_\_\_\_

5 \_\_\_\_\_

6 \_\_\_\_\_

What medications (drugs) do you take for these issues? State daily dosage.

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Under what circumstances do these problems improve?

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Under what circumstances do they worsen?

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What other illnesses have you had in the past ten years?

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# Nutrition Program Questionnaire

What operations have you had?

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What is your normal blood pressure? (Leave blank if unknown)

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What is your resting heart rate per minute?

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(You should be sitting down, relaxed and calm when you take your pulse. Your pulse can be found inside the bony protuberance on the thumb side of your wrist. Count the number of beats in 60 seconds.)

## **Fitness Profile**

How many hours/day do you workout?

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What sport or activities are you interested in improving your performance?

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How would you measure your current level in this sport/activity? Circle one.

Casual / Amateur / Semi-pro / Pro / Weekend warrior

When are you at your peak performance? After meals / Before meals

What kind of meals lead you to optimal performance?

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# Nutrition Program Questionnaire

## SYMPTOM ANALYSIS

Each symptom in this section can be associated with a nutritional deficiency. Please circle the conditions from which you often suffer and are looking to improve upon.

Mouth ulcers	Bleeding or tender gums	Muscle tremors or cramps
Acne	Easy bruising	Burning feet or tender heels
Dry flaky skin	Nose bleeds	Nausea or vomiting
Dandruff	Slow wound healing	Anxiety or tension
Thrush or cystitis	Red pimples on skin	Water retention
Diarrhea	Tender muscles	Prematurely graying hair
Frequent Urination	Poor concentration	Poor appetite
Backache	Poor memory	Dry eyes
Tooth decay	Stomach pains	PMS or breast pain
Hair loss	Constipation	Insomnia or nervousness
Muscle cramps or spasms	Overweight	High blood pressure
Joint pain/Stiffness/Arthritis	Tingling hands	Muscle weakness
Lack of energy	Dull or oily hair	High blood pressure
Exhaustion after light exercise	Eczema or Dermatitis	Irregular heartbeat
Easy bruising	Split nails	Hyperactivity
Varicose veins	Cracked lips	Tendency to depression
Loss of muscle tone	Insomnia	Sore knees
Frequent colds	Headaches or migraines	Excessive or cold sweats
Frequent infections	Depression	'Addicted' to or craving sweet foods
	Irritability	

# Nutrition Program Questionnaire

## LIFESTYLE ANALYSIS

Check any of the following that apply to you.

### Cardiovascular Profile

\_\_\_\_\_ Is your blood pressure above 140/90?

\_\_\_\_\_ Is your pulse after 15 minutes rest above 75?

\_\_\_\_\_ Are you more than 14lbs (7kg) over your ideal weight?

\_\_\_\_\_ Do you smoke more than 5 cigarettes per day?

\_\_\_\_\_ Do you do less than two hours exercise per week?

\_\_\_\_\_ Do you usually add salt to your food (if yes, what kind)? \_\_\_\_\_

\_\_\_\_\_ Do you have more than 2 alcoholic drinks per day?

\_\_\_\_\_ Is there a history of heart disease in your family?

\_\_\_\_\_ Is there a history of diabetes in your family?

\_\_\_\_\_ Is there a history of cancer in your family?

If yes to cancer, what kind? \_\_\_\_\_

### Acid/Toxin Risk Profile

\_\_\_\_\_ Do you drink bottled water?

\_\_\_\_\_ Do you consume dairy (if yes, what kind)? \_\_\_\_\_

\_\_\_\_\_ Do you consume meat (if yes, how many times per week)? \_\_\_\_\_

\_\_\_\_\_ Do you eat bread/pasta (if yes, how often)? \_\_\_\_\_

\_\_\_\_\_ Do you eat more than one spoonful of sugar per day?

\_\_\_\_\_ Do you consume coffee, soda, caffeinated tea, or carbonated water (circle any that apply)?

\_\_\_\_\_ Do you drink more than 1 unit or oz of alcohol per day?

(1 glass of wine, 1 pint of beer, or 1 measure of spirits)

\_\_\_\_\_ Do you spend a lot of time in front of a TV or computer?

# Nutrition Program Questionnaire

## Glucose Tolerance Profile

- \_\_\_\_\_ Do you need more than 8 hours sleep per night?
- \_\_\_\_\_ Are you rarely wide awake within 20 minutes of rising?
- \_\_\_\_\_ Do you need something to get going in the morning, tea or coffee?
- \_\_\_\_\_ 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?
- \_\_\_\_\_ Rate your energy, 0 being no energy, 10 being unstoppable energy

## Digestion Profile

- \_\_\_\_\_ Do you chew your food thoroughly?
- \_\_\_\_\_ Do you sometimes suffer from bad breath?
- \_\_\_\_\_ Are you prone to stomach upsets?
- \_\_\_\_\_ Do you often get a burning sensation in your stomach?
- \_\_\_\_\_ Do you find it difficult digesting fatty foods?
- \_\_\_\_\_ Do you suffer from acid reflux?
- \_\_\_\_\_ Do you occasionally use indigestion tablets?
- \_\_\_\_\_ Do you suffer from flatulence or bloating?
- \_\_\_\_\_ Do you experience anal irritation?
- \_\_\_\_\_ Do you have a bowel movement daily?
- \_\_\_\_\_ Do your stools float?

# Nutrition Program Questionnaire

## Immune Profile

- \_\_\_\_\_ Do you get more than three colds per year?
- \_\_\_\_\_ Do you find it hard to shift an infection (cold or otherwise)?
- \_\_\_\_\_ Are you prone to thrush or cystitis?
- \_\_\_\_\_ Do you often take antibiotics more than twice per year?
- \_\_\_\_\_ Have you ever had any growths or lumps biopsies?
- \_\_\_\_\_ Do you have an inflammatory disease, eczema, asthma or arthritis?
- \_\_\_\_\_ Do you suffer from hay fever?
- \_\_\_\_\_ Do you suffer from allergies?
- \_\_\_\_\_ Have you had a major personal loss in the last year?

## Histamine Profile

**Circle any of the following that apply to you.**

- |                     |                          |
|---------------------|--------------------------|
| Sleep over 8 hours  | 'Morning person'         |
| Little sex drive    | Sleep less than 7 hours  |
| Much body hair      | Little body hair         |
| Sluggish metabolism | Tends towards depression |
| Slow to wake up     | Don't put on weight      |
| Fast metabolism     | Poor tolerance to pain   |

# Nutrition Program Questionnaire

## Allergy Profile

Do you have allergies? YES NO

If YES, to what? \_\_\_\_\_

Do you suffer from any of the following? Circle all that apply.

Nasal problems

Dermatitis

Irritable bowel syndrome

Hay fever

Asthma

Frequent bloating

Eczema

Migraine

Facial puffiness

Have you been tested?

\_\_\_\_\_

What does your current daily diet look like (what does a typical day look like from waking to sleep)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

List all food supplements and medication you are currently taking.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What are your GOALS/OUTCOMES for this visit in regards to your health?

\_\_\_\_\_

\_\_\_\_\_

# Nutrition Program Questionnaire

## DIET ANALYSIS

Check for 'yes' or fill in the number.

1. \_\_\_\_\_ Were you breast fed?
2. \_\_\_\_\_ As a child, was a significant part of your diet high in fatty foods and sugar?
3. \_\_\_\_\_ Do you strongly avoid foods containing preservatives or additives?
4. \_\_\_\_\_ Do you use salt in your cooking?
5. \_\_\_\_\_ How many coffees do you drink each day?
6. \_\_\_\_\_ How many cups of tea do you drink each day?
7. \_\_\_\_\_ How many times/week do you have meals containing fried food?
8. \_\_\_\_\_ How many packets of 'instant' or fast foods do you at each week?
9. \_\_\_\_\_ How many times a week do you eat chocolate or confectionery?
10. \_\_\_\_\_ What percentage of your diet is raw fruit and raw vegetables?
11. \_\_\_\_\_ Do you wash fruit and vegetables before eating?
12. \_\_\_\_\_ Do you normally eat white rice or flour?
13. \_\_\_\_\_ How many glasses of milk do you drink in a week?
14. \_\_\_\_\_ How many times/week do you eat live yogurt?
15. \_\_\_\_\_ Do you drink filtered water instead of tap water?
16. \_\_\_\_\_ Do you frequently eat under stressful conditions or on the move?
17. \_\_\_\_\_ Does your job involve eating out a frequently?
18. \_\_\_\_\_ How would you describe your appetite? (a) Poor (b) Average (c) Good (d) Outstanding
19. \_\_\_\_\_ On a scale of 0-10 (10 being MOST, 0 being the LEAST), how would you rate your health?
20. \_\_\_\_\_ On a scale of 0-10 (10 being MOST, 0 being the LEAST), how would you rate your motivation to improve your health and desired outcome you mentioned?

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## Authorization

I certify that I'm the patient or legal guardian listed above. I have read/understand the included information and certify it to be true and accurate to the best of my knowledge. I consent to the collection and use of the above information to this office of chiropractic. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me.

I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for timely payment of such services. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and myself. I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent or Legal Guardian Signature (if patient is a minor): \_\_\_\_\_