



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 _____

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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.

Under what circumstances do these problems improve?

Under what circumstances do they worsen?

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

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What operations have you had?

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

What is your resting heart rate per minute?

(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?

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

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

Hyperactivity

Sore knees

'Addicted' to or craving
sweet foods

Tendency to depression

Excessive or cold sweats

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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?

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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?

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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 |

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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?

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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 eat 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): _____