

Nutritional Assessment Questionnaire

Name: _____

Date: ____/____/____

Birthdate: _____

Gender: _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

PART I

Read the following questions and fill in the number that applies:

KEY: 0 (or leave blank) = Do not consume or use 2 = Consume or use weekly
 1 = Consume or use 2-3 times/month 3 = Consume or use daily

DIET

- | | | |
|--------------------------------|------------------------------------|--------------------------------------|
| 1. _____ Alcohol | 8. _____ Coffee | 15. _____ Refined flour/ Baked goods |
| 2. _____ Artificial sweeteners | 9. _____ Eat fast food regularly | 16. _____ Refined sugar |
| 3. _____ Candy or other sweets | 10. _____ Fried foods | 17. _____ Vitamins and minerals |
| 4. _____ Carbonated beverages | 11. _____ Luncheon meats/ hot dogs | 18. _____ Water, distilled |
| 5. _____ Chewing tobacco | 12. _____ Margarine | 19. _____ Water, Tap |
| 6. _____ Cigarettes | 13. _____ Milk products | 20. _____ Water, well |
| 7. _____ Cigars/pipes | 14. _____ Non-herbal tea | 21. _____ Diet often |

LIFESTYLE

22. _____ Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week)
23. _____ Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)
24. _____ Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)
25. _____ Work over 60 hours/week (3= always, 2= usually, 1= occasionally, 0= never)

MEDICATIONS

Indicate with a checkmark or circle any medications you're currently taking or have taken in the last month:

- | | | | |
|-----------------------------|--------------------------------|---------------------------------|---------------------------------------|
| 26. _____ Antacids | 32. _____ Asthma inhalers | 38. _____ Estrogen/Progesterone | 44. _____ Oral/implant contraceptives |
| 27. _____ Antibiotics | 33. _____ Beta blockers | 39. _____ Heart medications | 45. _____ Radiation exposure |
| 28. _____ Anticonvulsants | 34. _____ Chemotherapy | 40. _____ High blood pressure | 46. _____ Recreational drugs |
| 29. _____ Antidepressants | 35. _____ Cortisone | 41. _____ Hormone Therapy | 47. _____ Relaxants/Sleeping pills |
| 30. _____ Antifungals | 36. _____ Diabetic medications | 42. _____ Laxatives | 48. _____ Thyroid medication |
| 31. _____ Aspirin/Ibuprofen | 37. _____ Diuretics | 43. _____ Insulin | 49. _____ Tylenol/acetaminophen |
| | | | 50. _____ Ulcer medications |

Other medications and dosages (if known): _____

PART II

Read the following questions and fill in the number that applies:

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: 0 (or leave blank) = No or Do not have the symptom, the symptom does not occur
 1 = Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
 2 = It is a moderate symptom or it occasionally occurs (weekly)
 3 = It is a severe symptom or it frequently occurs (daily)

Section 1

- | | |
|--|--|
| 51. _____ Belching or gas within 1 hr. of a meal | 60. _____ Do you feel like skipping breakfast? |
| 52. _____ Heartburn or acid reflux | 61. _____ Do you feel better if you don't eat? |
| 53. _____ Bloating shortly after eating | 62. _____ Sleepy after meals |
| 54. _____ Are you a vegan (no dairy, meat, fish or eggs) | 63. _____ Fingernails chip, peel or break easily |
| 55. _____ Bad breath (halitosis) | 64. _____ Anemia unresponsive to iron |
| 56. _____ Loss of taste for meat | 65. _____ Stomach pains or cramps |
| 57. _____ Sweat has a strong odor | 66. _____ Diarrhea, chronic |
| 58. _____ Stomach upset by taking vitamins | 67. _____ Diarrhea shortly after meals |
| 59. _____ Sense of excess fullness after meals | 68. _____ Black or tarry stools |
| | 69. _____ Undigested food in stool |