

## Medical Nutrition & Health Questionnaire

Date
------

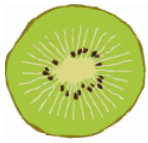
Please answer the following questions. Some may not apply and may be left unanswered. Please be as thorough and specific as possible.

### Personal Information

Full Name	Nickname	Date of Birth
Address	City	State ZIP
Home Phone	Work Phone	Mobile Phone
Email	SS#	Marital Status
Briefly describe why you are seeking nutritional counseling services.		
What do you feel are your biggest nutritional challenges and difficulties?		

### Weight History

Height	Current Weight	How long have you been at this weight?	Do you feel healthy at this weight? <input type="checkbox"/> Yes <input type="checkbox"/> No
What was your highest weight?		How long ago were you at this weight?	How long did you maintain this weight?
What do you think is your ideal weight?		How long ago were you at this ideal weight?	How long did you maintain this weight?
Was it easy to maintain your ideal weight? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you recently gained or lost weight? <input type="checkbox"/> Gained <input type="checkbox"/> Lost Amount:	If so, over what time frame did you gain or lose this weight?
Describe your weight history. Has it been steady? Does it yo-yo? Are you a lifetime dieter? Include any past weight-loss attempts.			
What strategies for past weight-loss have been successful for you?			
What strategies for past weight-loss have been unsuccessful for you?			

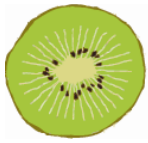


Lifestyle Factors

<b>WORK</b> Occupation		How many hours per week do you work?	
<b>HOME</b> If you have kids, list their names, ages, and genders here		Do any of your family members have special needs? If so, who? Describe their situation.	
<b>PHYSICAL ACTIVITY</b> Type		Duration	Hours / Minutes
Intensity <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High	Frequency (times/week)	Are you consistent? <input type="checkbox"/> Yes <input type="checkbox"/> No	Regardless of your exercise program, are you sedentary for most of the day? <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>SLEEP</b> Average hours of sleep per night		Do you awake feeling well rested? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you often have trouble falling asleep? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have sleep apnea? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	If you have sleep apnea, is it being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wake up at night? <input type="checkbox"/> Yes <input type="checkbox"/> No How many times?	If you know why, please explain.		
<b>STRESS</b> Do you have an unusually high amount of stress in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes			
Do you have appropriate outlets for coping & dealing with stress? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Sometimes			
Describe your current stress-reduction methods (such as mediation, yoga, breathing).		Most of your stress is due to what?	

Personal Medical History

Do you have or have you ever had:			
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Food allergies/sensitivities Explain: _____	
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Cancer Type: _____	<input type="checkbox"/> Lactose intolerant	
<input type="checkbox"/> Pregnant	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Celiac disease	
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Drug abuse	<input type="checkbox"/> Auto-immune disorder Explain: _____	
<input type="checkbox"/> Hypoglycemia	<input type="checkbox"/> Chronic constipation	<input type="checkbox"/> Other Explain: _____	
<input type="checkbox"/> Post-menopausal	<input type="checkbox"/> Sleep apnea		
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Migraines		
<input type="checkbox"/> Stroke	<input type="checkbox"/> Shortness of breath		
<input type="checkbox"/> Eating disorder Type: _____	<input type="checkbox"/> Thyroid disorder		
Do you frequently experience:			
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Colds/flu	<input type="checkbox"/> Muscle twitches	<input type="checkbox"/> Tingling in fingers/toes
<input type="checkbox"/> Constipation	<input type="checkbox"/> Water retention	<input type="checkbox"/> Irregular periods (females only)	<input type="checkbox"/> PMS
<input type="checkbox"/> Bloating/gas	<input type="checkbox"/> Sinus problems	<input type="checkbox"/> Bleeding gums	<input type="checkbox"/> Low immune system (frequent illnesses)
<input type="checkbox"/> Dry skin	<input type="checkbox"/> Headaches	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Nausea
<input type="checkbox"/> Heartburn/reflux	<input type="checkbox"/> Allergies	<input type="checkbox"/> Canker sores	<input type="checkbox"/> Cracks on corners of lips
<input type="checkbox"/> Light-headed/dizzy	<input type="checkbox"/> Mood swings	<input type="checkbox"/> Brittle nails	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what type?	If yes, how much (how often, how many)?	Do you want to quit? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Describe your current and past use of diuretics, diet pills, and laxatives.			



### Current Medical Information

Primary Care Physician (PCP)		Phone
Referring Practitioner (if different from PCP)		Phone
<b>LABWORK</b> Total cholesterol	LDL	HDL
Cholesterol/HDL ratio	Triglycerides	Homocysteine
Blood Pressure	C-Reactive Protein	Lp(a)
Glucose	HgA1c	Other labs
Current medications (prescription & over-the-counter), dietary supplements & herbs:		
Has anyone informed you of drug-nutrient interactions for your prescriptions medications? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, what have you been told?

### Family Medical History

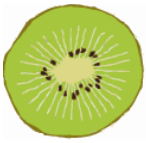
Has anyone in your family experienced:		
<input type="checkbox"/> Diabetes Type: _____	<input type="checkbox"/> Thyroid disorder	<input type="checkbox"/> Celiac disease
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Other
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer Type: _____	Explain: _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Alcoholism	_____
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Drug abuse	_____

### Food and Eating

#### Food Frequency

How often do you eat the following foods? Check the appropriate box next to each food.

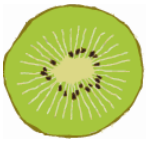
	Never	Once a Month	Once a Week	2 to 4 times a Week	Daily		Never	Once a Month	Once a Week	2 to 4 times a Week	Daily	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fruit & fruit juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Poultry
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Vegetables & vegetable juices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eggs
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Soy/soy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Condiments
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nuts/seeds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Butter/Margarine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nut butters (i.e. peanut butter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Olive oil/canola oil
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Beans/legumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other fats/oils
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dairy/calcium-rich foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fried foods
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Snack/junk food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Desserts
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"White" processed foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Candy/soda
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Whole grains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Red Meat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Water/Other beverages



### A Typical Day's Food Intake

In the appropriate column below, write down the typical foods you eat from day to day. Include everything that passes your lips, including fluid intake and solid foods. Also record portion sizes according to the Portion Size chart below.

	Weekdays	Weekends
Breakfast		
Morning Snack		
Lunch		
Afternoon Snack		
Dinner		
Evening Snack		
Midnight Snack		



How long have you been eating like this? \_\_\_\_\_

Do you eat like this consistently?  Yes  No

Have you recently made any changes to your diet?  Yes  No

If so, what are they? \_\_\_\_\_  
\_\_\_\_\_

When did you implement these changes? \_\_\_\_\_

Are you conscious of what and how much you put in your mouth?  Yes  No  Sometimes

Are you an emotional eater?  Yes  No  Sometimes

How often do you your emotions drive you to eat? \_\_\_\_\_

Do you eat more on days that you're overly stressed?  Yes  No

How often do you feel overly stressed? \_\_\_\_\_

Do you eat more when you're tired?  Yes  No  Sometimes

How often are you lacking sleep and feeling tired? \_\_\_\_\_

Are you often ravenous before meals?  Yes  No

Are you often overly full at the end of a meal?  Yes  No

How many meals do you eat AT home each week (include breakfast, lunch & dinner)? \_\_\_\_\_

How many meals do you eat AWAY from home each week? \_\_\_\_\_

Which meals do you most often eat AWAY from home?  Breakfast  Lunch  Dinner

Do you like to cook?  Yes  No

Do you feel you eat a wide variety of foods?  Yes  No  Unsure

Do you drink enough water throughout the day?  Yes  No  Unsure

Do you feel bored with the foods you eat?  Yes  No  Sometimes

Do you have a history of following fad diets?  Yes  No

If yes, which ones have you followed? \_\_\_\_\_  
\_\_\_\_\_

What are your overall nutritional goals? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

How ready and willing are you to make the changes necessary for achieving your goals?

Not at all	Slightly Ready		Fairly Ready		Very Ready					
Ready or Willing	& Willing		& Willing		& Willing					
0	1	2	3	4	5	6	7	8	9	10

How did you hear about Essential Nutrition? \_\_\_\_\_

\_\_\_\_\_