ALIVE + WELL

Nutrition Counseling Questionnaire

GENERAL INFORMATION

Name: _____ Date of Birth: _____ Weight: _____ Height: _____
Occupation: _____

CURRENT HEALTH CONCERNS

What goals to do you hope to achieve during your visit?
1) _____
2) _____
3) _____

When was the last time you felt well? _____
_____
Did something trigger your change in health? _____
_____

What makes you feel better? _____
What makes you feel worse? _____

Please list current and past problems in order of priority.

Describe Problem (ex. Headaches, Post Nasal Drip, Digestive Issues, etc.)	**Mild**	**Moderate**	**Severe**

Of the problems listed above, what prior treatment or approaches if any have you tried?

Prior Treatment/Approach (ex. Elimination Diet, medications, supplements, etc.)	**Excellent**	**Good**	**Fair**

MEDICAL HISTORY

Check the boxes that apply. Includes dates of onset where applicable.

P = Past condition **C = C**urrent condition

P C Gastrointestinal

- Irritable Bowel Syndrome _____
- Irritable Bowel Disease _____
- Crohn's _____
- Ulcerative Colitis _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

P C Cardiovascular

- Heart Attack _____
- Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Rheumatic Fever _____
- Mitral Valve Prolapse _____
- Other _____

P C Musculoskeletal/Pain

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

P C Respiratory Diseases

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____

P C Skin Diseases

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Other _____

P C Genital and Urinary Systems

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile Dysfunction or Sexual Dysfunction _____
- Other _____

P C Neurologic/Mood

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Autism _____
- Mild Cognitive Impairment _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other _____

P C Cancer

- Lung Cancer _____
- Breast Cancer _____
- Colon Cancer _____
- Ovarian Cancer _____
- Prostate Cancer _____
- Other _____

P C Metabolic/Endocrine

Type 1 Diabetes _____
Type 2 Diabetes _____
Hypoglycemia _____
Metabolic Syndrome (insulin resistance or prediabetes) _____
Hypothyroidism (low thyroid) _____
Hyperthyroidism (overactive thyroid) _____
Endocrine Problems _____
Polycystic Ovarian Syndrome (PCOS) _____
Infertility _____
Weight Gain _____
Weight Loss _____
Frequent Weight Fluctuations _____
Bulimia _____
Anorexia _____
Binge Eating Disorder _____
Night Eating Syndrome _____
Eating Disorder (non-specific) _____
Other _____

P C Inflammatory/Autoimmune

Chronic Fatigue Syndrome _____
Autoimmune Disease _____
Rheumatoid Arthritis _____
Lupus/SLE _____
Immune Deficiency Disease _____
Herpes-Genital _____
Severe Infections Disease _____
Poor Immune Function (frequent infections) _____
Food Allergies _____
Environmental Allergies _____
Multiple Chemical Sensitivities _____
Latex Allergy _____
Other _____

SURGERIES

Provide date of surgery if applicable.

Appendectomy _____
Hysterectomy _____
Gall Bladder _____
Hernia _____
Tonsillectomy _____

Dental Surgery _____
Joint Replacement _____
Heart Surgery _____
Angioplasty or Stent _____
Pacemaker _____

INJURIES

Provide date of injury if applicable.

Back Injury _____
Neck Injury _____
Head Injury _____

Broken Bones _____
Other _____

GI HISTORY

Foreign Travel? Yes ____ No ____
Wilderness Camping? Yes ____ No ____
Have you ever had severe: Gastroenteritis ____ Diarrhea ____
Do you feel like you digest your food well? Yes ____ No ____
Do you feel bloated after meals? Yes ____ No ____

GYNECOLOGIC HISTORY [FEMALE ONLY]

Age at first period: ____ Cycle frequency: ____ Length: ____
Has your period ever skipped? Yes ____ No ____
Last menstrual period: _____
Do you use contraception? Yes ____ No ____

Have you experienced any of the following (*check the box if it applies*):

____ Clotting
____ Fibrocystic Breasts
____ Painful Periods
____ Hot Flashes
____ Vaginal Dryness
____ Joint Pain
____ Endometriosis
____ Heavy Periods
____ Mood Swings
____ Decreased Libido
____ Headaches
____ Loss of Control of Urine
____ Breast Biopsy
____ Heart Palpitations
____ Hormone Replacement Therapy
____ Fibroids
____ Infertility
____ PMS
____ Concentration/Memory Problems
____ Heavy Bleeding
____ Weight Gain

In menopause? Yes ____ No ____
Age at menopause: ____
Date of last PAP test: _____ Normal ____ Abnormal ____
Date of last mammogram: _____ Normal ____ Abnormal ____
Date of last bone density scan: _____ High ____ Low ____

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes ____ No ____
Have you ever made any changes in your eating habits because of your health? Yes ____ No ____
Do you currently follow a special diet or nutritional program? Yes ____ No ____
Do you eat organic? Yes ____ No ____
Do you know about GMO foods? Yes ____ No ____
How often do you weigh yourself? Yes ____ No ____
Have you ever had your metabolism (resting metabolic rate) checked? Yes ____ No ____
Do you avoid any particular foods? Yes ____ No ____
If you could only eat a few foods a week, what would they be?
_____
_____
_____
Do you grocery shop? Yes ____ No ____
Do you read food labels? Yes ____ No ____
Do you cook? Yes ____ No ____
How many meals do you eat out per week? ____

Check all factors that apply to your current lifestyle and eating habits:

____ Fast eater
____ Erratic eating plan
____ Eat too much
____ Late night eating
____ Dislike healthy food
____ Time constraints
____ Eat more than 50% meals away from home
____ Travel frequently
____ Non-availability of health foods
____ Do not plan meals or menus
____ Reliance on convenience items
____ Poor snack choices
____ Significant other or family members don't like healthy foods
____ Significant other or family members have special dietary needs or food preferences
____ Love to eat
____ Eat because I have to
____ Have a negative relationship to food
____ Struggle with eating issues
____ Emotional eater (eat when sad, lonely, depressed, bored)
____ Eat too much under stress
____ Don't care to cook
____ Eating in the middle of the night
____ Confused about nutrition advice

What would you change about your diet to improve your health? _____
_____

ALCOHOL INTAKE

How many drinks currently per week? (*check the box that applies*):
None ____ 1-3 ____ 4-6 ____ 7-10 ____ >10 ____
Previous alcohol intake? Yes ____ No ____
Have you ever been told you should cut down on your alcohol intake? Yes ____ No ____
Do you get annoyed when people ask you about your drinking? Yes ____ No ____
Do you ever feel guilty about your alcohol consumption? Yes ____ No ____
Do you ever take an eye-opener? Yes ____ No ____
Do you notice a tolerance to alcohol (can you "hold" more than others)? Yes ____ No ____
Have you ever been unable to remember what you did during a drinking episode? Yes ____ No ____
Do you get into arguments or physical fights when you have been drinking? Yes ____ No ____
Have you ever thought about getting help to control or stop your drinking? Yes ____ No ____

OTHER SUBSTANCES

Caffeine Intake Yes ____ No ____
Are you currently using any recreational drugs? Yes ____ No ____
Have you ever used IV or inhaled recreational drugs? Yes ____ No ____
Currently smoking? Yes ____ No ____
Previous smoking? Yes ____ No ____
Second hand smoke exposure? Yes ____ No ____

EXERCISE

Stretching
Type: _____
How often: _____

Cardio/Aerobics
Type: _____
How often: _____

Strength training
Type: _____
How often: _____

Sports or leisure activities
Type: _____
How often: _____

Rate your level of motivation for including exercise in your life: Low ____ Medium ____ High ____
List problems that limit activity: _____
_____
Do you feel unusually fatigued after exercise? Yes ____ No ____
Do you usually sweat when exercising? Yes ____ No ____

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? Yes ____ No ____
Are you happy? Yes ____ No ____
Do you feel your life has meaning and purpose? Yes ____ No ____
Do you like the work you do? Yes ____ No ____
Have you experienced major losses in your life? Yes ____ No ____
Would you describe your experience as a child in your family as happy and secure? Yes ____ No ____

STRESS/COPING

Have you ever sought counseling? Yes ____ No ____
Are you currently in therapy? Yes ____ No ____
Do you feel you have an excessive amount of stress in your life? Yes ____ No ____
Do you feel you can easily handle the stress in your life? Yes ____ No ____

Daily stressors – Rate on a scale of 1-10
Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____

Do you practice meditation or relaxation techniques? Yes ____ No ____
Have you ever been abused, a victim of crime, or experienced a significant trauma? Yes ____ No ____

SLEEP/REST

Average number of hours you sleep per night (*check the box that applies)*:
____ >10 ____ 8-10 ____ 6-8 ____ <6
Do you have trouble falling asleep? Yes ____ No ____
Do you feel rested upon awakening? Yes ____ No ____
Do you have problems with insomnia? Yes ____ No ____
Do you snore? Yes ____ No ____
Do you use sleeping aides? Yes ____ No ____

ENVIRONMENTAL AND DETOX ASSESSMENT

Do you have any food allergies, sensitivities, or adverse food reactions? Yes ____ No ____
Do you have an adverse reaction to caffeine? Yes ____ No ____
Do you adversely react to (*check all that apply*):

____ Cheese
____ Red wine
____ Aspartame
____ Bananas
____ Citrus
____ Sulfite-containing foods (wine, dried fruit, salad bars)
____ Preservatives (ex. Sodium benzoate)
____ Garlic
____ Onion
____ Alcohol
____ Monosodium glutamate (MSG)
____ Chocolate
____ Cigarette smoke
____ Exhaust fumes
____ Perfume/colognes
____ Other

Have you ever turned yellow (jaundiced)? Yes ____ No ____
Have you ever been told you have Gilbert's syndrome or a liver disorder? Yes ____ No ____

Do you have a known history of significant exposure to any harmful chemicals such as the following (*check all that apply*):

____ Chemicals
____ Electromagnetic radiation
____ Herbicides
____ Heavy metals
____ Pesticides
____ Insecticides (frequent visits of exterminator)
____ Organic solvents
____ Other

Do you dry clean your clothes frequently? Yes ____ No ____
Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes ____ No ____
Do you have any pets or farm animals? Yes ____ No ____

MSQ – MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

Report your Symptoms for the last 48 hours: 0 = never or almost never have the symptom 1 = occasionally have it, effects not severe 2 = occasionally have, effects severe 3 = frequently have it, effect is not severe 4 = frequently have it, effect is severe

Digestive Tract
_____ Nausea of vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Heartburn
_____ Intestinal/Stomach pain
Digestive Total: _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Ears Total: _____

Joints/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Joints/Muscles Total: _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness or breath
_____ Difficult breathing
Lungs Total: _____

Emotions
_____ Mood sings
_____ Anxiety, fear, or nervousness
_____ Anger, irritability, or aggressiveness
_____ Depression
Energy Total: _____

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Energy/Activity Total: _____

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near or far-sightedness)
Eyes Total: _____

Mouth/Throat
_____ Chronic couching
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gum, lips
_____ Canker sores
Mouth/Throat Total: _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Mind Total: _____

Skin
_____ Acne
_____ Hives, rashes or dry skin
_____ Hair loss
_____ Flushing or hot flushes
_____ Excessive sweating
Skin Total: _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
Nose Total: _____

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Head Total: _____

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Weight Total: _____

Other
_____ Frequent illness
_____ Frequent urgent urination
_____ Genital itch or discharge
Other symptom Total: _____

GRAND TOTAL: _____

MEDICATIONS/SUPPLEMENTS

Please list current medications/supplements you are taking.

Medication/Supplement	Reason

Have any of your medications or supplements ever caused you unusual side effects or problems? If yes, please describe: _____
_____

Have you used any of these regularly for a long time:
NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? Yes ____ No ____
Tylenol (acetaminophen)? Yes ____ No ____
Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)? Yes ____ No ____
Frequent antibiotics (more than 3 times/year)? Yes ____ No ____
Long term antibiotics? Yes ____ No ____
Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes ____ No ____
Use of oral contraceptives? Yes ____ No ____
Use of statins? Yes ____ No ____

ALLERGIES/SENSITIVITIES

List any allergies or sensitivities you have to medications, foods, or supplements.

Substance	Reaction

3-DAY FOOD DIARY

Complete this food diary prior to your appointment.

DAY 1:

TIME OF DAY	FOOD	NOTES

Thoughts/Feelings/Emotions: _____

_____

_____

DAY 2:

TIME OF DAY	FOOD	NOTES

Thoughts/Feelings/Emotions: _____

_____

_____

DAY 3:

TIME OF DAY	FOOD	NOTES

Thoughts/Feelings/Emotions: _____
_____
_____

READINESS ASSESSMENT

Rate your readiness or willingness to do the following things (1 being the lowest, 5 being the highest)

Significantly modify your diet ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Take several nutrition supplements each day ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Keep a record of everything you eat each day ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Modify your lifestyle (e.g., work demands, sleep habits) ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Practice a relaxation technique ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Engage in regular exercise ____ 1 ____ 2 ____ 3 ____ 4 ____ 5
Have period lab tests to assess your progress ____ 1 ____ 2 ____ 3 ____ 4 ____ 5

How confident are you of your ability to organize and follow through on the above health related activities?
____ 1 ____ 2 ____ 3 ____ 4 ____ 5

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?
____ 1 ____ 2 ____ 3 ____ 4 ____ 5

How much personal ongoing support and contact (e.g., telephone consults, email correspondence) would be helpful to you as you implement your personal health program?
____ 1 ____ 2 ____ 3 ____ 4 ____ 5