

Nutritional Assessment Questionnaire

Name: _____ Date: _____

Address: _____ Gender: _____

_____ Telephone: _____

Emergency Contact Name / Number: _____ / _____

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

1. _____

2. _____

3. _____

Please circle if you have the following: Organ Transplant / Shunt / Stint / Cadaver Bone / Live Tissue / Pace Maker

Have you ever had a seizure? Yes / No

DENTAL: Do you have tooth implants, amalgam fillings, root canal, bridges, or any other metal in your mouth? Yes / No

SURGERIES: Type: _____ Year: _____

PART 1

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

KEY: 0 (or 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

| | | |
|-----------------------|-------------------------|---------------------------|
| Alcohol | Coffee | Refined flour/Baked Goods |
| Artificial Sweeteners | Eat Fast Food regularly | Refined Sugar |
| Candy or other sweets | Fried Foods | Vitamins and Minerals |
| Carbonated beverages | Luncheon meats/hot dogs | Water, distilled |
| Chewing tobacco | Margarine | Water, Tap |
| Cigarettes | Milk Products | Water, Well |
| Cigars/pipes | Non-herbal Tea | Diet often |

LIFESTYLE

| |
|--|
| Times you exercise per week (1 = once a week, 2 = 2 – 4 times per week, 3= t times per week) |
| Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months) |
| Divorced (3= within lasts 6 months, 2= within last year, 1=within last 2 years) |
| Work over 60 hours per week (3= always, 2= usually, 1=occasionally, 0= never) |

MEDICATIONS – Indicate with an X with any medications currently taken or have taken in last month

| | | | |
|-------------------|----------------------|-----------------------|-----------------------------|
| Antacids | Asthma Inhalers | Estrogen/Progesterone | Oral/implant contraceptives |
| Antibiotics | Beta Blockers | Heart Medications | Radiation exposure |
| Anticonvulsants | Chemotherapy | High Blood Pressure | Recreational drugs |
| Antidepressants | Cortisone | Hormone Therapy | Relaxants/Sleeping pills |
| Antifungals | Diabetic Medications | Laxatives | Thyroid medication |
| Aspirin/ibuprofen | Diuretics | Insulin | Tylenol/acetaminophen |
| | | | Ulcer medications |

Other medications and dosages: _____

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 1 = Yes or Minor or Mild symptom (once a month or less) 3 = Sever symptom, frequently occurs (daily)

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PART 2

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 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 – Upper Gastrointestinal System

| | | | |
|--|---------------------------------------|--|--|
| | Belching or gas within 1 hour of meal | | Do you feel like skipping breakfast? |
| | Heartburn or acid reflux | | Do you feel better if you don't eat? |
| | Bloating shortly after eating | | Sleepy after meals |
| | Vegan (no dairy, meat, fish or eggs) | | Fingernails chip, peel or break easily |
| | Bad breath (halitosis) | | Anemia unresponsive to iron |
| | Loss of taste for meat | | Stomach pains or cramps |
| | Sweat has a strong odor | | Diarrhea, chronic |
| | Stomach upset by taking vitamins | | Diarrhea shortly after meals |
| | Sense of excess fullness after meals | | Black or tarry stools |
| | | | Undigested food in stool |

SECTION 2 – Liver and Gallbladder

| | | | |
|--|--|--|---|
| | Pain between shoulder blades | | Alcoholic beverages per week (0=<3/week, 1=<7/week, 2=<14 week, 3=>14 week) |
| | Stomach upset by greasy foods | | Recovering alcoholic (1=yes, 0=no) |
| | Greasy or shiny stools | | Hangovers after drinking alcohol |
| | Nausea | | History of drug or alcohol abuse (1=yes, 2=no) |
| | Sea, car or airplane sickness/motion sickness | | History of hepatitis (1=yes, 2=no) |
| | History of morning sickness (1=yes, 2=no) | | Long term use of prescription meds (1=yes, 2=no) |
| | Light or clay colored stools | | Sensitive to chemicals (perfume, cleans solvents, exhaust) |
| | Dry skin, itchy feet and/or skin peels on feet | | Sensitive to tobacco smoke |
| | Headache over eye | | Exposure to diesel fumes |
| | Gallbladder attacks (past or present) | | Pain under right side of rib cage |
| | Gallbladder removed (1=yes, 2=no) | | Hemorrhoids or varicose veins |
| | Bitter taste in mouth, especially after meals | | Nutrasweet (aspartame) consumption |
| | Become sick if drinking wine | | Bothered by aspartame (Nutrasweet) |
| | If drinking alcohol, easily intoxicated | | Chronic fatigue or Fibromyalgia |

SECTION 3- Small Intestine

| | | | |
|--|--|--|---|
| | Food Allergies | | Crohn's disease (1 = yes, 0 = no) |
| | Abdominal bloating 1 to 2 hours after eating | | Wheat or grain sensitivity |
| | Specific foods make you tired or bloated (1=yes) | | Dairy sensitivity |
| | Pulse speeds after eating | | Are there foods you could not give up (1=yes, 0=no) |
| | Airborne allergies | | Asthma, sinus infections, stuffy nose |
| | Experience hives | | Bizarre vivid or nightmarish dreams |
| | Sinus congestion, "stuffy head" | | Use over-the-counter pain medications |
| | Crave bread or noodles | | Feel spacey or unreal |
| | Alternating constipation and diarrhea | | |

SECTION 4 – Large Intestine

| | | | |
|--|---|--|---|
| | Anus itches | | Less than one bowel movement per day |
| | Coated tongue | | Stools have corners or edges, are flat or ribbon shaped |
| | Feel worse in moldy or musty places | | Stools are not well formed (loose) |
| | Taken any antibiotic for a combined time of (1= <month, 2= < 3 months, 3= > 3 months) | | Irritable bowel or mucus colitis |
| | Fungus or yeast infections | | Blood in stool |
| | Ring worm, "jock itch", "athlete's foot", nail fungus | | Mucus in stool |
| | Eating sugar, starch or drinking alcohol increase yeast symptoms | | Excessive foul smelling lower bowel gas |
| | Stools hard or difficult to pass | | Cramping in lower abdominal region |
| | History of parasites (1 = yes, 0 = no) | | Dark circles under eyes |

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SECTION 5 – Mineral Needs

| | |
|--|-------------------------------------|
| History of Carpal Tunnel Syndrome (1=y, 0=n) | Morning stiffness |
| History of lower right abdominal pain (1=y, 0=n) | Vomiting or nausea |
| History of stress fractures | Crave chocolate |
| Bone loss (reduced density on bone scan) | Feet have a strong odor |
| Are you shorter than you used to be? (1=y, 0=n) | Tendency to anemia |
| Calf, foot or toe cramps at rest | Whites of eyes are blue tinted |
| Cold sores, fever blisters or herpes lesions | Hoarseness |
| Frequent fevers | Difficulty swallowing |
| Frequent skin rashes and/or hives | Lump in throat |
| Have you ever had a herniated disc? (1=y, 0=n) | Dry mouth, eyes and/or nose |
| Excessively flexible joints, “double jointed” | Gag easily |
| Joints pop or click | White spots on fingernails |
| Pain or swelling in joints | Cuts heal slowly and/or scar easily |
| Bursitis or tendonitis | Decreased sense of taste or smell |
| History of bone spurs (1=y, 0=n) | |

SECTION 6 – Essential Fatty Acids

| | |
|--|--|
| Aspirin is an effective pain reliever (1=y, 0=n) | Headaches when out in the hot sun |
| Crave fatty or greasy foods | Sunburn easily or suffer sun poisoning |
| Low or reduced fat diet (past or present) | Muscles easily fatigued |
| Tension headaches at base of skull | Dry flaky skin and or dandruff |

SECTION 7 – Sugar Handling

| | |
|--|---|
| Awaken a few hours after falling asleep, hard to get back to sleep | Fatigue that is relieved by eating |
| Crave sweets | Headache if meals are skipped or delayed |
| Eat desserts or sugary snacks | Irritable before meals |
| Binge or uncontrolled eating | Shaky if meals delayed |
| Excessive appetite | Family members with diabetes (0= non, 1= 2 or less, 2=between 2-4, 3=more than 4) |
| Crave coffee or sugar in afternoon | Frequent thirst |
| Sleepy in afternoon | Frequent urination |

SECTION 8 – Vitamin Need

| | |
|--|---|
| Muscles become easily fatigued | Can hear heart beat on pillow at night |
| Feel worse, sore after moderate exercise | Whole body or limb jerk as falling asleep |
| Vulnerable to insect bites | Night sweats |
| Loss of muscle tone, heaviness in arms/legs | Restless leg syndrome |
| Enlarged heart, or heart failure | Chellosis (cracks in corner of mouth) |
| Pulse slow/ below 65 (1=y, 0=n) | Fragile skin, easily chaffed, as in shaving |
| Ringings in ears / Tinnitus | Polyps or warts |
| Numbness, tingling or itching in extremities | MSG sensitivity |
| Depressed | Wake up without remembering dreams |
| Fear of impending doom | Take birth control pills |
| Worrier, apprehensive, anxious | Small bumps on back of arms |
| Nervous or agitated | Strong light at night irritates eyes |
| Feelings or insecurity | Nose bleeds and/or tend to bruise easily |
| Heart races | Bleeding gums, especially when brushing teeth |

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SECTION 9 – Adrenal

| | |
|---|---|
| Tend to be a “night person” | Arthritic tendencies |
| Difficulty falling asleep | Crave salty foods |
| Slow starter in the morning | Salt foods before tasting |
| Keyed up, trouble calming down | Perspire easily |
| High blood pressure (normal 120/80) | Chronic fatigue, or get drowsy often |
| Headache after exercising | Afternoon yawning |
| Feeling wired or jittery if drinking coffee | Afternoon headache |
| Clench or grind teeth | Asthma, wheezing or difficulty breathing |
| Calm on the outside, troubled on the inside | Pain on the medial or inner side of knee |
| Chronic low back pain, worse with fatigue | Tendency to sprain ankles or “shin splints” |
| Become dizzy when standing up suddenly | Tendency to need to wear sunglasses |
| Difficult maintaining manipulative correction | Allergies and/or hives |
| Pain after manipulative correction | Weakness, dizziness |

SECTION 10 – Pituitary

| | |
|--|--|
| Over 5’6” tall (mature height) | Under 4’10” tall (mature height) |
| Early sexual development <10 years (1=y, 0p=n) | Decreased libido |
| Increased libido | Abnormal thirst |
| Splitting type headache | Weight gain around hips or waist |
| Memory failing | Menstrual disorders |
| Ability to tolerate sugar | Delayed (after 13) sexual development (y=1, 2=n) |
| | Tendency to ulcers or colitis |

SECTION 11 – Thyroid

| | |
|---|---|
| Allergic to iodine | Mentally sluggish, reduced initiative |
| Difficulty gaining weight, even with large appetite | Easily fatigued, sleepy during the day |
| Nervous, emotional, can’t work under pressure | Sensitive to cold, poor circulation (cold hands and feet) |
| Inward trembling | Constipation, chronic |
| Flush easily | Excessive hair loss and/or coarse hair |
| Fast pulse at rest | Morning headaches, wear off during the day |
| Intolerance to high temperatures | Loss of lateral 1/3 of eyebrow |
| Difficulty losing weight | Seasonal sadness |

SECTION 12 – Men Only

| | |
|--|---|
| Prostate problems | Waking to urinate at night |
| Urination difficult or dribbling | Interruption of stream during urination |
| Difficult to start and stop urine stream | Pain on inside of legs or heels |
| Pain or burning with urination | Felling of incomplete bowel evacuation |
| | Decreased sexual function |

SECTION 13 – Women Only

| | |
|---|--|
| Depression during periods | Breast fibroids, benign masses |
| Mood swings associated with periods (PMS) | Painful intercourse (dyspareunia) |
| Crave chocolate around periods | Vaginal discharge |
| Breast tenderness associated with cycle | Vaginal dryness |
| Excessive menstrual flow | Vaginal itchiness |
| Scanty blood flow during periods | Gain weight around hips, thighs and buttocks |
| Occasional skipped periods | Excess facial or body hair |
| Variations in menstrual cycles | Hot flashes |
| Endometriosis | Night sweats (in menopausal females) |
| Uterine fibroids | Thinning skin |

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SECTION 14 – Cardiovascular

| | | | |
|--|--|--|--|
| | Aware of heavy and/or irregular breathing | | Ankles swell, especially at end of day |
| | Discomfort at high altitudes | | Cough at night |
| | “Air hunger” and/or yawn frequently | | Blush or face turns red for no reason |
| | Compelled to open windows in a closed room | | Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| | Shortness of breath with moderate exertion | | Muscle cramps with exertion |

SECTION 15 – Kidney and Bladder

| | | | |
|--|---|--|----------------------------------|
| | Pain in mid back region | | Cloudy, bloody or darkened urine |
| | Dark circles under eyes and/or puffy eyes | | Urine has a strong odor |
| | History of kidney stones (1=yes, 0=no) | | |

SECTION 16 – Immune system

| | | | |
|--|---|--|---|
| | Runny or drippy nose | | Acne (adult) |
| | Catch colds at the beginning of winter | | Itchy skin / dermatitis |
| | Mucus producing cough | | Cysts, boils, rashes |
| | Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.) | | History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis, or other chronic viral conditions (1=yes, 0=no) |
| | Frequent colds or flu | | |
| | Never get sick (3 = not 1 last 7 years, 2 = not in last 4 years, 1 = not in last 2 years) | | |

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