

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 |

Nutritional Assessment Questionnaire

Section 2

70. Pain between shoulder blades
71. Stomach upset by greasy foods
72. Greasy or shiny stools
73. Nausea
74. Sea, car or airplane sickness, motion sickness
75. History of morning sickness (1 = yes, 0 = no)
76. Light or clay colored stools
77. Dry skin, itchy feet and/or skin peels on feet
78. Headache over the eye
79. Gallbladder attacks (past or present)
80. Gallbladder removed (1 = yes, 0 = no)
81. Bitter taste in mouth, especially after meals
82. Become sick if drinking wine
83. If drinking alcohol, easily intoxicated
84. Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
85. Recovering alcoholic (1 = yes, 0 = no)
86. Hangovers after drinking alcohol
87. History of drug or alcohol abuse (1 = yes, 0 = no)
88. History of hepatitis (1 = yes, 0 = no)
89. Long term use of prescription medications (1 = yes, 0 = no)
90. Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91. Sensitive to tobacco smoke
92. Exposure to diesel fumes
93. Pain under right side of rib cage
94. Hemorrhoids or varicose veins
95. Nutrasweet (aspartame) consumption
96. Bothered by aspartame (NutraSweet)
97. Chronic fatigue or Fibromyalgia

Section 3

98. Food allergies
99. Abdominal bloating 1 to 2 hours after eating
100. Specific foods make you tired or bloated (1 = yes, 0 = no)
101. Pulse speeds after eating
102. Airborne allergies
103. Experience hives
104. Sinus congestion, "stuffy head"
105. Crave bread or noodles
106. Alternating constipation and diarrhea
107. Crohn's disease (1 = yes, 0 = no)
108. Wheat or grain sensitivity
109. Dairy sensitivity
110. Are there foods you could not give up (1 = yes, 0 = no)
111. Asthma, sinus infections, stuffy nose
112. Bizarre vivid or nightmarish dreams
113. Use over-the-counter pain medications
114. Feel spacey or unreal

Section 4

115. Anus itches
116. Coated tongue
117. Feel worse in moldy or musty place
118. Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
119. Fungus or yeast infections
120. Ring worm, "jock itch", "athletes foot", nail fungus
121. Eating sugar, starch or drinking alcohol increases yeast symptoms
122. Stools hard or difficult to pass
123. History of parasites (1 = yes, 0 = no)
124. Less than one bowel movement per day
125. Stools have corners or edges are flat or ribbon shaped
126. Stools are not well formed (loose)
127. Irritable bowel or mucus colitis
128. Blood in stool
129. Mucus in stool
130. Excessive foul smelling lower bowel gas
131. Bad breath or strong body odors
132. Painful to press along outer sides of thighs (Iliotibial Band)
133. Cramping in lower abdominal region
134. Dark circles under eyes

Section 5

135. History of Carpal Tunnel Syndrome (1 = yes, 0 = no)
136. History of lower right abdominal pain (1 = yes, 0 = no)
137. History of stress fractures
138. Bone loss (reduced density on bone scan)
139. Are you shorter than you used to be? (1 = yes, 0 = no)
140. Calf, foot or toe cramps at rest
141. Cold sores, fever blisters or herpes lesions
142. Frequent fevers
143. Frequent skin rashes and / or hives
144. Have you ever had a herniated disc? (1 = yes, 0 = no)
145. Excessively flexible joints, "double jointed"
146. Joints pop or click
147. Pain or swelling in joints
148. Bursitis or tendonitis
149. History of bone spurs (1 = yes, 0 = no)
150. Morning stiffness
151. Vomiting or nausea
152. Crave chocolate
153. Feet have a strong odor
154. Tendency to anemia
155. Whites of eyes (sclera) blue tinted
156. Hoarseness
157. Difficulty swallowing
158. Lump in throat
159. Dry mouth, eyes and / or nose
160. Gag easily
161. White spots on fingernails
162. Cuts heal slowly and / or scar easily
163. Decreased sense of taste or smell

Key: 0 (or leave blank) = No or Do not have symptom, symptom does not occur
1 = Yes or Minor or mild symptom (once a month or less)

2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

Section 6

164. ___ Aspirin is an effective pain reliever (1 = yes, 0 = no)
165. ___ Crave fatty or greasy foods
166. ___ Low or reduced fat diet (past or present)
167. ___ Tension headaches at base of skull
168. ___ Headaches when out in the hot sun
169. ___ Sunburn easily or suffer sun poisoning
170. ___ Muscles easily fatigued
171. ___ Dry flaky skin and or dandruff

Section 7

172. ___ Awaken a few hours after falling asleep, hard to get back to sleep
173. ___ Crave sweets
174. ___ Eat desserts or sugary snacks
175. ___ Binge or uncontrolled eating
176. ___ Excessive appetite
177. ___ Crave coffee or sugar in the afternoon
178. ___ Sleepy in afternoon
179. ___ Fatigue that is relieved by eating
180. ___ Headache if meals are skipped or delayed
181. ___ Irritable before meals
182. ___ Shaky if meals delayed
183. ___ Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4)
184. ___ Frequent thirst
185. ___ Frequent urination

Section 8

186. ___ Muscles become easily fatigued
187. ___ Feel worse, sore after moderate exercise
188. ___ Vulnerable to insect bites
189. ___ Loss of muscle tone, heaviness in arms / legs
190. ___ Enlarged heart, or heart failure
191. ___ Pulse slow / below 65 (1 = yes, 0 = no)
192. ___ Ringing in the ears / Tinnitus
193. ___ Numbness, tingling or itching in extremities
194. ___ Depressed
195. ___ Fear of impending doom
196. ___ Worrier, apprehensive, anxious
197. ___ Nervous or agitated
198. ___ Feelings of insecurity
199. ___ Heart races
200. ___ Can hear heart beat on pillow at night
201. ___ Whole body or limb jerk as falling asleep
202. ___ Night sweats
203. ___ Restless leg syndrome
204. ___ Cheilosis (cracks at corner of mouth)
205. ___ Fragile skin, easily chaffed, as in shaving
206. ___ Polyps or warts
207. ___ MSG sensitivity
208. ___ Wake up without remembering dreams
209. ___ Take birth control pills
210. ___ Small bumps on back of arms
211. ___ Strong light at night irritates eyes
212. ___ Nose bleeds and / or tend to bruise easily
213. ___ Bleeding gums especially when brushing teeth

Section 9

214. ___ Tend to be a "night person"
215. ___ Difficulty falling asleep
216. ___ Slow starter in the morning
217. ___ Keyed up, trouble calming down
218. ___ High blood pressure (normal 120/80)
219. ___ Headache after exercising
220. ___ Feeling wired or jittery if drinking coffee
221. ___ Clench or grind teeth
222. ___ Calm on the outside, troubled inside
223. ___ Chronic low back pain, worse with fatigue
224. ___ Become dizzy when standing up suddenly
225. ___ Difficult maintaining manipulative correction
226. ___ Pain after manipulative correction
227. ___ Arthritic tendencies
228. ___ Crave salty foods
229. ___ Salt foods before tasting
230. ___ Perspire easily
231. ___ Chronic fatigue, or get drowsy often
232. ___ Afternoon yawning
233. ___ Afternoon headache
234. ___ Asthma, wheezing or difficulty breathing
235. ___ Pain on the medial or inner side of the knee
236. ___ Tendency to sprain ankles or "shin splints"
237. ___ Tendency to need to wear sunglasses
238. ___ Allergies and / or hives
239. ___ Weakness, dizziness

Section 10

240. ___ Over 6' 6" tall (Mature height)
241. ___ Early sexual development (before age 10) (1 = yes, 0 = no)
242. ___ Increased libido
243. ___ Splitting type headache
244. ___ Memory failing
245. ___ Ability to tolerate sugar
246. ___ Under 4' 10" (Mature height)
247. ___ Decreased libido
248. ___ Abnormal thirst
249. ___ Weight gain around hips or waist
250. ___ Menstrual disorders
251. ___ Delayed (after age 13) sexual development (1 = yes, 0 = no)
252. ___ Tendency to ulcers or colitis

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Section 11

253. ___ Allergic to iodine
254. ___ Difficulty gaining weight, even with large appetite
255. ___ Nervous, emotional, can't work under pressure
256. ___ Inward trembling
257. ___ Flush easily
258. ___ Fast pulse at rest
259. ___ Intolerance to high temperatures
260. ___ Difficulty losing weight
261. ___ Mentally sluggish, reduced initiative
262. ___ Easily fatigued, sleepy during the day
263. ___ Sensitive to cold, poor circulation (cold hands and feet)
264. ___ Constipation, chronic
265. ___ Excessive hair loss and / or coarse hair
266. ___ Morning headaches, wear off during the day
267. ___ Loss of lateral 1/3 of eyebrow
268. ___ Seasonal sadness

Section 12 – Men Only

269. ___ Prostate problems
270. ___ Urination difficult or dribbling
271. ___ Difficult to start and stop urine stream
272. ___ Pain or burning with urination
273. ___ Waking to urinate at night
274. ___ Interruption of stream during urination
275. ___ Pain on inside of legs or heels
276. ___ Feeling of incomplete bowel evacuation
277. ___ Decreased sexual function

Section 13 – Women Only

278. ___ Depression during periods
279. ___ Mood swings associated with periods (PMS)
280. ___ Crave chocolate around periods
281. ___ Breast tenderness associated with cycle
282. ___ Excessive menstrual flow
283. ___ Scanty blood flow during periods
284. ___ Occasional skipped periods
285. ___ Variations in menstrual cycles
286. ___ Endometriosis
287. ___ Uterine fibroids
288. ___ Breast fibroids, benign masses
289. ___ Painful intercourse (dyspareunia)
290. ___ Vaginal discharge
291. ___ Vaginal dryness
292. ___ Vaginal itchiness
293. ___ Gain weight around hips, thighs and buttocks
294. ___ Excess facial or body hair
295. ___ Hot flashes
296. ___ Night sweats (in menopausal females)
297. ___ Thinning skin

Section 14

298. ___ Aware of heavy and / or irregular breathing
299. ___ Discomfort at high altitudes
300. ___ "Air hunger" and / or yawn frequently
301. ___ Compelled to open windows in a closed room
302. ___ Shortness of breath with moderate exertion
303. ___ Ankles swell, especially at end of day
304. ___ Cough at night
305. ___ Blush or face turns red for no reason
306. ___ Dull pain or tightness in chest and / or radiate into right arm, worse with exertion
307. ___ Muscle cramps with exertion

Section 15

308. ___ Pain in mid back region
309. ___ Dark circles under eyes and / or puffy eyes
310. ___ History of kidney stones (1 = yes, 0 = no)
311. ___ Cloudy, bloody or darkened urine
312. ___ Urine has a strong odor

Section 16

313. ___ Runny or drippy nose
314. ___ Catch colds at the beginning of winter
315. ___ Mucus producing cough
316. ___ Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
317. ___ Frequent colds or flu
318. ___ Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.)
319. ___ Acne (adult)
320. ___ Itchy skin / dermatitis
321. ___ Cysts, boils, rashes
322. ___ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no)

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