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 
1 = Consume or use 2-3 times/month
2 = Consume or use weekly
3 = Consume or use daily

DIET
1. _____ Alcohol 2. _____ Artificial sweeteners 3. _____ Candy or other sweets 4. _____ Carbonated beverages
5. _____ Chewing tobacco 6. _____ Cigarettes 7. _____ Cigars/pipes
8. _____ Coffee 9. _____ Eat fast food regularly 10. _____ Fried foods 11. _____ Luncheon meats/ hot dogs
15. _____ Refined flour/ Baked goods 16. _____ Refined sugar 17. _____ Vitamins and minerals 18. _____ Water, distilled

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 27. _____ Antibiotics 28. _____ Anticonvulsants 29. _____ Antidepressants
30. _____ Antifungals 31. _____ Aspirin/Ibuprofen 32. _____ Asthma inhalers 33. _____ Beta blockers
34. _____ Chemotherapy 35. _____ Cortisone 36. _____ Diabetic medications 37. _____ Diuretics
38. _____ Estrogen/Progestrone 39. _____ Heart medications 40. _____ High blood pressure
41. _____ Hormone Therapy 42. _____ Laxatives 43. _____ Insulin 44. _____ Oral/implant contraceptives
45. _____ Radiation exposure 46. _____ Recreational drugs 47. _____ Relaxants/Sleeping pills
48. _____ Thyroid medication 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 52. _____ Heartburn or acid reflux
53. _____ Bloating shortly after eating 54. _____ Are you a vegan (no dairy, meat, fish or eggs)
55. _____ Bad breath (halitosis) 56. _____ Loss of taste for meat
57. _____ Sweat has a strong odor 58. _____ Stomach upset by taking vitamins
59. _____ Sense of excess fullness after meals 60. _____ Do you feel like skipping breakfast?
61. _____ Do you feel better if you don’t eat? 62. _____ Sleepy after meals
63. _____ Fingernails chip, peel or break easily 64. _____ Anemia unresponsive to iron
65. _____ Stomach pains or cramps 66. _____ Diarrhea, chronic
67. _____ Diarrhea shortly after meals 68. _____ Black or tarry stools
69. _____ Undigested food in stool
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. _____ Alcoholics 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 rashess 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 tendinitis
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
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. _____ Arthritis tendencies  
228. _____ Crave salty foods  
229. _____ Salt foods before tasing  
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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2 = Between 2 - 4, 3 = More than 4
### Nutritional Assessment Questionnaire

#### 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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