PRIVATE AND CONFIDENTIAL

Nutrition Questionnaire

the nutritional institute
FOOD | NUTRITION | EDUCATION

NAME	**DATE OF BIRTH**
ADDRESS	**PHONE** • ………………………………………... (H) • ………………………………………... (W) • ………………………………………... (C)
POST CODE	
EMAIL	
GP NAME	**GP ADDRESS (if known)**

Do you give permission for your GP to be contacted if required?

Do you currently see any other health care practitioners?
If yes, for what reason?

What would you like to achieve from consulting with the Nutritional Institute?

____

____

____

To what extent are you prepared to modify your lifestyle (based on our recommendations) in order to improve your health and fitness?

____

____

CONSULTATION AGREEMENT

I agree to the following conditions for the upcoming consultation with my nutrition practitioner(s):

- The information I provide via questionnaires, phone, email, in-person, or by any other means of communication is accurate to the best of my knowledge.
- The recommendations I will receive from my practitioner(s) are not a substitute for medical advice from a qualified doctor.
- The advice I will receive from my practitioner is personal and applies to me only - this same advice may be ineffective or even harmful when applied to other people with a different background.
- I must communicate to my practitioner(s) with regards to any changes in my medical prescriptions or treatments for the duration of my nutrition intervention.
- I must inform my practitioner(s) promptly if any of my new changes in diet or lifestyle start to cause me adverse effects.
- I understand that the advice I shall receive will not be enough to achieve my nutrition or lifestyle goals unless I follow it diligently and commit to it fully.
- I understand that any changes in my diet and lifestyle may produce effects in my body, energy, health, and condition that are gradual in nature – not instantaneous.
- I understand that, although my practitioner(s) will endeavour to help me achieve my nutrition and lifestyle goals to the best extent possible, there is a possibility that I don't fully attain my goals due to factors outside of their control.

I have read and understood the terms above and I agree to them - please sign and date below:

Name:________________________________ **Date:**_________________________

PERSONAL HEALTH HISTORY

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. At the end of each section, write the total in the box.

KEY: **Leave blank (0) = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2-3 times/month **3 = Consume or use daily**

DIET & LIFESTYLE

1. _____ Alcohol
2. _____ Artificial sweeteners
3. _____ Candy, desserts, refined sugar
4. _____ Carbonated beverages
5. _____ Chewing tobacco
6. _____ Cigarettes
7. _____ Cigars/pipes
8. _____ Caffeinated drinks
9. _____ Fast foods
10. _____ Fried foods
11. _____ Luncheon meats/ hot dogs
12. _____ Margarine
13. _____ Milk products
14. _____ Radiation exposure (0=no, 1=yes)
15. _____ Refined flour/ baked goods
16. _____ Vitamins and minerals
17. _____ Diet often for weight control
18. _____ Water, distilled
19. _____ Water, tap
20. _____ Water, well

21. _____ Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never or less than once a month)
22. _____ Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. _____ Divorced (0 = never or over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. _____ Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS

Indicate with a number 2 any medications you're currently taking or have taken in the last 12 months (0 = no, 2 = yes):

25. _____ Antacids
26. _____ Antianxiety meds.
27. _____ Antibiotics
28. _____ Anticonvulsants
29. _____ Antidepressants
30. _____ Antifungals
31. _____ Aspirin/Ibuprofen
32. _____ Asthma inhalers
33. _____ Beta blockers
34. _____ Birth control pill or Implant contraceptives
35. _____ Chemotherapy
36. _____ Cholesterol lowering
37. _____ Cortisone/steroids
38. _____ Diabetic medication
39. _____ Diuretics
40. _____ Oestrogen or progesterone (synthetic)
41. _____ Oestrogen or progesterone (natural)
42. _____ Heart medication
43. _____ High Blood Pressure
44. _____ Laxatives
45. _____ Recreational drugs
46. _____ Relaxants/Sleeping pills
47. _____ Testosterone (natural or synthetic)
48. _____ Thyroid medication
49. _____ Paracetamol/ acetaminophen
50. _____ Ulcer medications
51. _____ Viagra/Sidenafal citrate

Other medications and dosages (if known): ______________________________

PART II

Read the following questions and fill in the number that applies. At the end of each section, write the total in the box.

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: **Leave blank (0) = 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

55

52. _____ Belching or gas within 1 hr. of eating
53. _____ Heartburn or acid reflux
54. _____ Bloating shortly after eating
55. _____ Vegan diet (no dairy, meat, fish, eggs) (0=no, 1=yes)
56. _____ Bad breath (halitosis)
57. _____ Loss of taste for meat
58. _____ Sweat has a strong odor
59. _____ Stomach upset by taking vitamins
60. _____ Sense of excess fullness after meals
61. _____ Feel like skipping breakfast
62. _____ Feel better if you don't eat
63. _____ Sleepy after meals
64. _____ Fingernails chip, peel or break easily
65. _____ Anemia unresponsive to iron
66. _____ Stomach pains or cramps
67. _____ Diarrhea, chronic
68. _____ Diarrhea shortly after meals
69. _____ Black or tarry coloured stools
70. _____ Undigested food in stool

Total

Key: Leave blank (0) = **No** or Do not have symptom, symptom does not occur 2 = Moderate symptom, occurs occasionally (weekly)
1 = **Yes** or Minor or mild symptom (once a month or less) 3 = Severe symptom, frequently occurs (daily)

Section 2 – Liver and Gallbladder

68

71. _____ Pain between shoulder blades
72. _____ Stomach upset by greasy foods
73. _____ Greasy or shiny stools
74. _____ Nausea
75. _____ Sea, car or airplane sickness, motion sickness
76. _____ History of morning sickness (0=no, 1=yes)
77. _____ Light or clay coloured stools
78. _____ Dry skin, itchy feet and/or skin peels on feet
79. _____ Headache over the eyes
80. _____ Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within last 3 months
81. _____ Gallbladder removed (0=no, 1=yes)
82. _____ Bitter taste in mouth, especially after meals
83. _____ Become sick if drinking wine (0=no, 1=yes)
84. _____ If drinking wine, easily intoxicated (0=no, 1=yes)
85. _____ Easily hung over if you were to drink wine (0=no, 1=yes)
86. _____ Alcohol per week (0 = <3, 1 = <7, 2 = <14, 3 = >14)
87. _____ Recovering alcoholic (0=no, 1=yes)
88. _____ History of drug or alcohol abuse (0=no, 1=yes)
89. _____ History of hepatitis (0=no, 1=yes)
90. _____ Prescription/Recreational drugs used long-term (0=no, 1=yes)
91. _____ Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
92. _____ Sensitive to tobacco smoke
93. _____ Exposure to diesel fumes
94. _____ Pain under right side of rib cage
95. _____ Haemorrhoids or varicose veins
96. _____ Aspartame (Nutrasweet) consumption
97. _____ Sensitive to aspartame (Nutrasweet)
98. _____ Chronic Fatigue or Fibromyalgia

Total

Section 3 – Small Intestine

47

99. _____ Food allergies
100. _____ Abdominal bloating 1 to 2 hours after eating
101. _____ Specific foods make you tired or bloated (0=no, 1=yes)
102. _____ Pulse speeds after eating
103. _____ Airborne allergies
104. _____ Experience hives
105. _____ Sinus congestion, "stuffy head"
106. _____ Crave bread or noodles
107. _____ Alternating constipation and diarrhea
108. _____ Crohn's disease (0=no, 1=yes in the past, 2=currently mild condition, 3=severe)
109. _____ Wheat or grain sensitivity
110. _____ Dairy sensitivity
111. _____ Are there foods you could not give up (0=no, 1=yes)
112. _____ Asthma, sinus infections, stuffy nose
113. _____ Bizarre vivid dreams or nightmares
114. _____ Use over-the-counter pain medications
115. _____ Feel spacey or unreal

Total

Section 4 – Large Intestine

58

116. _____ Anus itches
117. _____ Coated tongue
118. _____ Feel worse in moldy or musty place
119. _____ Taken any antibiotic for a total accumulated time of (0=never, 1 = <1 month, 2 = <3 months, 3 = >3 months)
120. _____ Fungus or yeast infections
121. _____ Ring worm, "jock itch", "athletes foot", nail fungus
122. _____ Yeast symptoms increase with sugar, starch or alcohol
123. _____ Stools hard or difficult to pass
124. _____ History of parasites (0=no, 1=yes)
125. _____ Less than one bowel movement per day
126. _____ Stools have corners or edges, are flat or ribbon shaped
127. _____ Stools are not well formed (loose)
128. _____ Irritable bowel or mucus colitis
129. _____ Painful to press along outer sides of thighs (Iliotibial Band)
130. _____ Mucus in stool
131. _____ Excessive foul smelling lower bowel gas
132. _____ Bad breath or strong body odors
133. _____ Blood in Stool
134. _____ Cramping in lower abdominal region
135. _____ Dark circles under eyes

Total

Section 5 – Mineral Needs

75

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

Total

Key: Leave blank (0) = **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)

Section 6 – Essential Fatty Acids

22

165. _____ Aspirin is an effective pain reliever (0=no, 1=yes)
166. _____ Crave fatty or greasy foods
167. _____ Low or reduced fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. _____ Tension headaches at base of skull
169. _____ Headaches when out in the hot sun
170. _____ Sunburn easily or suffer sun poisoning
171. _____ Muscles easily fatigued
172. _____ Dry flaky skin and or dandruff

Total

Section 7 – Sugar Handling

39

173. _____ Awaken a few hours after falling asleep, hard to get back to sleep
174. _____ Crave sweets
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. _____ Family members with diabetes (0 = none, 1 = 1 or 2, 2 = 3 or 4, 3 = more than 4)
181. _____ Headache if meals are skipped or delayed
182. _____ Irritable before meals
183. _____ Shaky if meals delayed
184. _____ Frequent thirst
185. _____ Frequent urination

Total

Section 8 – Vitamin Need

81

186. _____ Muscles become easily fatigued
187. _____ Feel exhausted or sore after moderate exercise
188. _____ Vulnerable to insect bites
189. _____ Loss of muscle tone, heaviness in arms / legs
190. _____ Enlarged heart or congestive heart failure
191. _____ Pulse below 65 beats per minute at rest (0=no, 1=yes)
192. _____ Ringing in the ears (Tinnitus)
193. _____ Numbness, tingling or itching in hands and feet
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. _____ Bleeding gums especially when brushing teeth
207. _____ MSG sensitivity
208. _____ Wake up without remembering dreams
209. _____ Small bumps on back of arms
210. _____ Strong light at night irritates eyes
211. _____ Nose bleeds and/or tend to bruise easily
212. _____ Polyps or warts

Total

Section 9 – Adrenal

78

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

Total

Section 10 – Pituitary

29

239. _____ Height over 6' 6" (1m 98cm) (0=no, 1=yes)
240. _____ Early sexual development (before age 10) (0=no, 1=yes)
241. _____ Increased libido
242. _____ Splitting type headache
243. _____ Memory failing
244. _____ Feel fine when eating sugar (0=no, 1=yes)
245. _____ Delayed (after age 13) sexual development (0=no, 1=yes)
246. _____ Decreased libido
247. _____ Excessive thirst
248. _____ Weight gain around hips or waist
249. _____ Menstrual disorders
250. _____ Under 4' 10" (Mature height)
251. _____ Tendency to ulcers or colitis

Total

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3 = Severe symptom, frequently occurs (daily)

Section 11 – Thyroid

48

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

Total

Section 12 – Men Only

27

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

Total

Section 13 – Women Only

60

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

Total

Section 14 – Cardiovascular

30

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

Total

Section 15 – Kidney and Bladder

13

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

Total

Section 16 – Immune system

30

312. _____ Runny or drippy nose
313. _____ Catch colds at the beginning of winter
314. _____ Mucus producing cough
315. _____ Frequent colds or flu (0 = 1 or less/year, 1 = 2 to 3/year, 2 = 4 to 5/year, 3 = 6 + /year)
316. _____ Other Infections (sinus, ear, lung, skin, bladder, kidney etc.) (0 = 1 or less/year, 1 = 2 to 3/year, 2 = 4 to 5/year, 3 = 6 + per year)
317. _____ Never get sick (0 = sick only 1 to 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
318. _____ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)
319. _____ Acne (adult)
320. _____ Itchy skin / dermatitis
321. _____ Cysts, boils, rashes

Total

Key: Leave blank (0) = **No** or Do not have symptom, symptom does not occur
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3 = Severe symptom, frequently occurs (daily)

FOOD DIARY

Please fill in a sample day of eating, drinking and exercise/activity that you do. Follow your usual routines and note everything as accurately as you can. Detail is important, so give an estimate of quantity in terms of spoons and cups (eg. ½ cups oats with ½ cup milk and 10 sliced strawberries). For activity or exercise, any movement is relevant. Also note stresses that you encountered during the day.

TIME	FOOD EATEN (+ Supplements)	FLUID CONSUMED	ACTIVITY OR EXERCISE
Between Rising and Breakfast			
Breakfast			
Between Breakfast and Lunch			
Lunch			
Between Lunch and Dinner			
Dinner			
Between Dinner and Bed			

Key: Leave blank (0) = **No** or Do not have symptom, symptom does not occur
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