

## NUTRITION QUESTIONNAIRE

Name \_\_\_\_\_ # \_\_\_\_\_ Date \_\_\_\_\_

**List of medications/vitamins now taking & why**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**List injuries, surgeries, etc. & date**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**Instructions:** Please check the symptoms you have/are experiencing in either (or both) of the **chronic (recurrent symptoms)** and **acute (symptoms you have now)**.

<b>Gastro-intestinal</b>			<b>Structural/Neurological</b>		
Acute	Chronic		Acute	Chronic	
_____	_____	Black or bloody stool	_____	_____	Back pain
_____	_____	Colitis, diverticulitis	_____	_____	Current bone fracture/injury
_____	_____	Digestive complaints	_____	_____	Dizziness
_____	_____	Frequent burping/belching	_____	_____	Headaches
_____	_____	Frequent constipation	_____	_____	Jaw pain
_____	_____	Frequent diarrhea	_____	_____	Joint pain or loss of function
_____	_____	Frequent heartburn	_____	_____	Knee pain/Hip pain (circle one)
_____	_____	Frequent vomiting	_____	_____	Muscle cramps /spasms
_____	_____	Gallbladder trouble	_____	_____	Neck pain
_____	_____	Hemorrhoids	_____	_____	Numbness/Tingling
_____	_____	Irritable bowel	_____	_____	Osteoporosis/Osteomalacia
_____	_____	Nausea	_____	_____	Shoulder, Elbow, Wrist pain (circle one)
_____	_____	Stomach pain	_____	_____	Tendonitis/ Bursitis
_____	_____	Ulcers	_____	_____	Tremors in hands or feet

<b>Immune Response</b>			<b>Cardiovascular</b>		
Acute	Chronic		Acute	Chronic	
_____	_____	Achy joints/muscle pain	_____	_____	Chest pain
_____	_____	Chronic fatigue	_____	_____	Hands & feet cold all the time
_____	_____	Depression and/or anxiety	_____	_____	Heart murmur/palpitations
_____	_____	Eczema of hives	_____	_____	High or low blood pressure
_____	_____	Food allergies	_____	_____	Irregular heartbeat
_____	_____	Frequently sick	_____	_____	Poor circulation
_____	_____	Frequent swollen glands/sore throats	_____	_____	Previous heart surgery
_____	_____	Headaches/migraines	_____	_____	Previous heart trouble
_____	_____	Recurrent digestive complaints	_____	_____	varicose or spider veins

<p><b>Respiratory</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; width: 10%;">Acute</th> <th style="text-align: left; width: 10%;">Chronic</th> <th style="width: 80%;"></th> </tr> <tr><td>_____</td><td>_____</td><td>Asthma</td></tr> <tr><td>_____</td><td>_____</td><td>Emphysema</td></tr> <tr><td>_____</td><td>_____</td><td>Chronic cough</td></tr> <tr><td>_____</td><td>_____</td><td>Recurrent bronchitis</td></tr> <tr><td>_____</td><td>_____</td><td>Recurrent head colds</td></tr> <tr><td>_____</td><td>_____</td><td>Recurrent sinus infections</td></tr> <tr><td>_____</td><td>_____</td><td>Smoker</td></tr> </table> <p><b>Genito-Urinary</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; width: 10%;">Acute</th> <th style="text-align: left; width: 10%;">Chronic</th> <th style="width: 80%;"></th> </tr> <tr><td>_____</td><td>_____</td><td>Bedwetting</td></tr> <tr><td>_____</td><td>_____</td><td>Blood in urine</td></tr> <tr><td>_____</td><td>_____</td><td>Discolored or foul-smelling urine</td></tr> <tr><td>_____</td><td>_____</td><td>Inability to control bladder</td></tr> <tr><td>_____</td><td>_____</td><td>Kidney stones</td></tr> <tr><td>_____</td><td>_____</td><td>Recurrent kidney or bladder infections</td></tr> <tr><td>_____</td><td>_____</td><td>Too frequent urination</td></tr> </table>	Acute	Chronic		_____	_____	Asthma	_____	_____	Emphysema	_____	_____	Chronic cough	_____	_____	Recurrent bronchitis	_____	_____	Recurrent head colds	_____	_____	Recurrent sinus infections	_____	_____	Smoker	Acute	Chronic		_____	_____	Bedwetting	_____	_____	Blood in urine	_____	_____	Discolored or foul-smelling urine	_____	_____	Inability to control bladder	_____	_____	Kidney stones	_____	_____	Recurrent kidney or bladder infections	_____	_____	Too frequent urination	<p><b>Endocrine (Glandular)</b></p> <table style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left; width: 10%;">Acute</th> <th style="text-align: left; width: 10%;">Chronic</th> <th style="width: 80%;"></th> </tr> <tr><td>_____</td><td>_____</td><td>Anxiety/nervousness/irritability</td></tr> <tr><td>_____</td><td>_____</td><td>Cold hands and feet</td></tr> <tr><td>_____</td><td>_____</td><td>Depression</td></tr> <tr><td>_____</td><td>_____</td><td>Diabetes</td></tr> <tr><td>_____</td><td>_____</td><td>Digestive complaints</td></tr> <tr><td>_____</td><td>_____</td><td>Dizzy when standing too quickly</td></tr> <tr><td>_____</td><td>_____</td><td>Frequent headaches</td></tr> <tr><td>_____</td><td>_____</td><td>Hyperactive behavior</td></tr> <tr><td>_____</td><td>_____</td><td>Irritable if meals are missed</td></tr> <tr><td>_____</td><td>_____</td><td>Low blood pressure</td></tr> <tr><td>_____</td><td>_____</td><td>Thyroid problems</td></tr> <tr><td>_____</td><td>_____</td><td>Weak and shaky</td></tr> <tr><td>_____</td><td>_____</td><td>Weight problems (over or under)</td></tr> <tr><td>_____</td><td>_____</td><td>Very susceptible to infections</td></tr> </table>	Acute	Chronic		_____	_____	Anxiety/nervousness/irritability	_____	_____	Cold hands and feet	_____	_____	Depression	_____	_____	Diabetes	_____	_____	Digestive complaints	_____	_____	Dizzy when standing too quickly	_____	_____	Frequent headaches	_____	_____	Hyperactive behavior	_____	_____	Irritable if meals are missed	_____	_____	Low blood pressure	_____	_____	Thyroid problems	_____	_____	Weak and shaky	_____	_____	Weight problems (over or under)	_____	_____	Very susceptible to infections
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PATIENT SIGNATURE _____	DATE _____
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<b><u>FOR DOCTORS USE ONLY</u></b>		
Axillary Temperature Test _____	Saliva pH _____	Urinary pH _____
Postural Blood Pressure: Recumbant _____	Standing _____	Pulse _____
Pupillary Light Reflex _____		
Diagnostic Summary: _____		
_____		