

# Nutritional Assessment Questionnaire

Nourishment - Energy & Structure

Name: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Birthdate: \_\_\_\_\_

Gender: \_\_\_\_\_

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

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## 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

- \_\_\_\_\_ Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week)
- \_\_\_\_\_ Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)
- \_\_\_\_\_ Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)
- \_\_\_\_\_ 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 – Upper Gastrointestinal System

- |  |  |
|--|--|
| 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               |

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### Section 2 – Liver and Gallbladder

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 – Small Intestine

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 – Large Intestine

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 – Mineral Needs

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

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### Section 6 – Essential Fatty Acids

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

### Section 7 – Sugar Handling

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

### Section 8 – Vitamin Need

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

### Section 9 – Adrenal

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

### Section 10 – Pituitary

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

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### Section 11 – Thyroid

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 – Cardiovascular

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 – Kidney and Bladder

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 – Immune system

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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