This Document has Interactive Form Fields.

Place your cursor and click in the field to type in your response. Use the Tab key to move on. The last page will do calculations automatically.

When complete, Save the form to your computer and attach to an email to Ruth, or print and bring to your appointment.

smart nutrition

Helping you look & feel 10 years younger

Nutritional Consultation Questionnaire

Date:_____

General Information

First name:_____ Middle:_____ Last: _____

Address:_____

City: _____ State:_____ Zip:_____

Phone (home): _____ Phone (work): _____

Cell phone: _____ E-mail:_____

Date of Birth: _____ Height:_____ Weight:_____ Blood Type:_____

Marital Status: _____ How many children do you have?_____

Occupation: _____ Do you like your current career?_____

How did you hear about our services?

_____

What are your most important health concerns?

_____

_____

_____

_____

What do you hope to achieve in your visit with us?

_____

_____

_____

_____

Lifestyle and Nutrition History

Do you drink caffeine? ☐ Yes ☐ No Cups per day ☐ 1 ☐ 2-4 ☐ >4

Do you drink soda? ☐ Yes ☐ No 12 oz can/bottle/day ☐ 1 ☐ 2-4 ☐ >4

Do you drink alcohol? ☐ Yes ☐ No How many drinks per week? ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10

Do you smoke? ☐ Yes ☐ No How many years? _____ Packs per day:_____
2nd Hand Smoke Exposure?_____

Do you use recreational drugs? ☐ Yes ☐ No Type: _____ How often?_____

Do you get noticeably irritable, light headed, or weak if you haven't eaten in a while? _____

Do you crave any of the following?

☐ Sugar ☐ Meat ☐ Fat ☐ Chocolate ☐ Fish ☐ Alcohol
☐ Desserts ☐ Milk ☐ Salt ☐ Bread ☐ Fried Foods ☐ Other _____

Which oils do you use/consume?

☐ Butter ☐ Peanut Oil ☐ Canola ☐ Margarine ☐ Corn Oil ☐ Sun/Safflower
☐ Olive Oil ☐ Crisco ☐ Mayonnaise ☐ Coconut Oil ☐ Vegetable Oil ☐ Flaxseed Oil
☐ Soybean Oil ☐ Other _____

Do you avoid any particular foods? ☐ Yes ☐ No
If yes, types and reasons?_____

_____

Do you overeat? ☐ Yes ☐ No If so, which foods and how often? _____

_____

Do you grocery shop? ☐ Yes ☐ No If no, who does the shopping?_____

Do you read food labels? ☐ Yes ☐ No

Do you cook? ☐ Yes ☐ No If no, who does the cooking?_____

How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5

Check all that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Eat more than 50% of meals away from home
☐ Travel frequently
☐ Don't plan meals or menus
☐ Non-availability of healthy foods
☐ Reliance on convenience items
☐ Poor snack choices
☐ Love to eat
☐ Household members don't like healthy foods
☐ Household members have special dietary needs or food preferences
☐ Emotional eater (eat when sad, lonely, depressed, stressed, bored)
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eat in the middle of the night
☐ Eat because I have to
☐ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is:

_____

_____

Rank your skin without lotion:
☐ Very Dry ☐ Dry ☐ Normal ☐ Oily ☐ Combination

How much water do you drink daily? _____

How often do you have bowel movements? _____

How often do you urinate? _____

Exercise

Do you exercise? _____

If so, what kind? _____

How often? _____

When did you start? _____

Energy

Please rate the following:

Daily energy level:
☐ Excellent ☐ Fair
☐ Good ☐ Poor

Energy level after exercise:
☐ Excellent ☐ Fair
☐ Good ☐ Poor

Daily stress level:
☐ Very High ☐ Moderate
☐ High ☐ Low

General enjoyment of life:
☐ Excellent ☐ Fair
☐ Good ☐ Poor

Sleep/Rest

How much sleep do you get on average each night?
☐ >10 hours ☐ 8-10 hours ☐ 6-8 hours ☐ <6 hours

Do you have trouble falling asleep? ☐ Yes ☐ No

Do you wake during the night? ☐ Yes ☐ No

Difficulty falling back to sleep? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you snore? ☐ Yes ☐ No

Do you have sleep apnea? ☐ Yes ☐ No

Do you use a cPAP machine? ☐ Yes ☐ No

Do you use any sleep aids? ☐ Yes ☐ No Explain_____

Stress/Coping

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No If yes, please describe: _____

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

Daily Stressors: Rate from 1-10 (10 being highest)

Work ___ Family___ Social___ Finances___ Health ___ Other ___

Do you practice meditation or relaxation technique? ☐ Yes ☐ No If yes, how often? _____

Check all that apply:

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other _____

❑ Have you ever been abused, a victim or a crime, or experienced a significant trauma? ☐ Yes ☐ No

Dental History

☐ Silver mercury fillings? How many? _____ ☐ Gold fillings ☐ Root canals ☐ Implants

☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Problems chewing

Do you floss regularly ☐ Yes ☐ No

☐ Other dental issues? _____

☐ Dental surgery? _____

Allergies/Sensitivities

Food/Supplement/ Medication/Environmental	**Reaction**

Weight History

_____

_____

_____

Medical Information

Please list all nutritional supplements, vitamins, prescriptions and over the counter medications that you take regularly, dosage and for what purpose. Attach a separate page, if necessary. Be sure to bring your supplement and medication bottles with you to your appointment.

Who is your primary care physician?

Name _____ Phone _____

Address _____

When was the last time you had a complete physical?_____

Please list any disease, illness, or ailments in your immediate family
(i.e. mother-breast cancer, father-type II diabetic, etc.)

Please feel free to expand on any concerns you think are important and relevant to your health.

smart nutrition

Helping you look & feel 10 years younger

Medical History

Please check off any of the following past or current diagnosis or conditions.

KEY: ❍ = past condition ❑ = current condition

Autoimmune/Inflammatory

- ❍ ☐ Autoimmune Disease
- ❍ ☐ Chronic Fatigue Syndrome
- ❍ ☐ Environmental Allergies
- ❍ ☐ Food Allergies
- ❍ ☐ Herpes-Genital
- ❍ ☐ Immune Deficiency Disease _____
- ❍ ☐ Lupus
- ❍ ☐ Multiple Chemical Sensitivities
- ❍ ☐ Poor Immune Function (frequent infections)
- ❍ ☐ Rheumatoid Arthritis
- ❍ ☐ Severe Infectious Disease
- ❍ ☐ Other _____

Cancer

- ❍ ☐ Breast Cancer
- ❍ ☐ Colon Cancer
- ❍ ☐ Lung Cancer
- ❍ ☐ Melanoma
- ❍ ☐ Ovarian Cancer
- ❍ ☐ Prostate Cancer
- ❍ ☐ Skin Cancer
- ❍ ☐ Other _____

Cardiovascular

- ❍ ☐ Arrhythmia (irregular heart beat)
- ❍ ☐ Heart Attack
- ❍ ☐ High Cholesterol
- ❍ ☐ Hypertension (high blood pressure)
- ❍ ☐ Hypotension (low blood pressure)
- ❍ ☐ Mitral Valve Prolapse
- ❍ ☐ Rheumatic Fever
- ❍ ☐ Stroke
- ❍ ☐ Other _____

Endocrine/Metabolic

- ❍ ☐ Anorexia
- ❍ ☐ Binge Eating Disorder
- ❍ ☐ Bulimia
- ❍ ☐ Endocrine Problems
- ❍ ☐ Frequent Weight Fluctuation
- ❍ ☐ Hair Loss/Poor Hair Growth
- ❍ ☐ Hyperthyroidism (overactive thyroid)
- ❍ ☐ Hypoglycemia (low blood sugar)
- ❍ ☐ Hypothyroidism (low thyroid)
- ❍ ☐ Infertility
- ❍ ☐ Metabolic Syndrome (Insulin Resistance or Pre-Diabetes)
- ❍ ☐ Night Eating Syndrome
- ❍ ☐ Type 1 Diabetes
- ❍ ☐ Type 2 Diabetes
- ❍ ☐ Weight Gain
- ❍ ☐ Weight Loss
- ❍ ☐ Other _____

Genital and Urinary Systems

- ❍ ☐ Bladder Infections (Cystitis)
- ❍ ☐ Gout
- ❍ ☐ Kidney Stones
- ❍ ☐ Urinary Tract Infections (frequent)
- ❍ ☐ Yeast infections (frequent)
- ❍ ☐ Other _____

Gastrointestinal

- ❍ ☐ Celiac Disease
- ❍ ☐ Constipation
- ❍ ☐ Crohn's
- ❍ ☐ Diarrhea/Loose Stools
- ❍ ☐ Gas/Bloating/Indigestion
- ❍ ☐ Gastritis or Peptic Ulcer Disease
- ❍ ☐ GERD (reflux)
- ❍ ☐ Heart Burn
- ❍ ☐ Hemorrhoids
- ❍ ☐ Inflammatory Bowel Disease
- ❍ ☐ Irritable Bowel Syndrome
- ❍ ☐ Malabsorbtion
- ❍ ☐ Parasites
- ❍ ☐ Ulcerative Colitis
- ❍ ☐ Other _____

KEY: ❍ = past condition ❑ = current condition

Musculoskeletal/Pain
- ❍ ☐ Chronic Pain
- ❍ ☐ Fibromyalgia
- ❍ ☐ Osteoarthritis
- ❍ ☐ Other _____

Neurologic/Mood
- ❍ ☐ ADD/ADHD
- ❍ ☐ Addiction (alcohol, drugs)
- ❍ ☐ ALS
- ❍ ☐ Anxiety or Nervousness
- ❍ ☐ Autism
- ❍ ☐ Bipolar Disorder
- ❍ ☐ Depression
- ❍ ☐ Emotional Problems (instability, sensitivity)
- ❍ ☐ Headaches
- ❍ ☐ Memory Problems
- ❍ ☐ Migraines
- ❍ ☐ Mild Cognitive Impairment
- ❍ ☐ Multiple Sclerosis
- ❍ ☐ Panic Attacks
- ❍ ☐ Parkinson's Disease
- ❍ ☐ Ringing in Ears
- ❍ ☐ Schizophrenia
- ❍ ☐ Seizures
- ❍ ☐ Severe Mood Swings
- ❍ ☐ Suicidal Tendencies
- ❍ ☐ Other _____

Respiratory
- ❍ ☐ Asthma
- ❍ ☐ Bronchitis
- ❍ ☐ Emphysema
- ❍ ☐ Pneumonia
- ❍ ☐ Sinusitis (chronic)
- ❍ ☐ Sleep Apnea
- ❍ ☐ Other _____

Skin/Nails
- ❍ ☐ Acne
- ❍ ☐ Cold Sores
- ❍ ☐ Eczema
- ❍ ☐ Dandruff
- ❍ ☐ Hives
- ❍ ☐ Nails (poor growth)
- ❍ ☐ Nails – (white spots)
- ❍ ☐ Psoriasis
- ❍ ☐ Other _____

Other
- ❍ ☐ Anemia
- ❍ ☐ Fainting/Dizziness
- ❍ ☐ Gallbladder Problems
- ❍ ☐ Hepatitis
- ❍ ☐ Insomnia
- ❍ ☐ Jaundice
- ❍ ☐ Liver Problems
- ❍ ☐ Other _____

Women - check any that pertain:
- ❍ ☐ Birth Control Pills, Patch, Ring
- ❍ ☐ Decreased Libido
- ❍ ☐ Endometriosis
- ❍ ☐ Fibrocystic Breasts
- ❍ ☐ Fibroids
- ❍ ☐ Heavy Periods
- ❍ ☐ Hot Flashes/Night Sweats
- ❍ ☐ Hysterectomy
- ❍ ☐ Infertility
- ❍ ☐ Irregular Periods
- ❍ ☐ Loss of Libido
- ❍ ☐ Loss of Periods
- ❍ ☐ Menopause
- ❍ ☐ Painful Intercourse
- ❍ ☐ Painful Periods
- ❍ ☐ PMS
- ❍ ☐ Polycystic Ovarian Syndrome (PCOS)
- ❍ ☐ Pregnant/Nursing
- ❍ ☐ Other _____

Men – check any that pertain:
- ❍ ☐ Difficulty Urination
- ❍ ☐ Difficulty with Erection
- ❍ ☐ Frequent Urination
- ❍ ☐ Loss of Libido
- ❍ ☐ Night Sweats
- ❍ ☐ Prostrate Enlargement
- ❍ ☐ Other _____

Surgeries

Check box if yes and provide date following type of surgery

- ☐ None
- ☐ Angioplasty ☐
- ☐ Appendectomy ☐
- ☐ Dental Surgery ☐
- ☐ Gallbladder ☐
- ☐ Heart Surgery ☐
- ☐ Hernia ☐
- ☐ Hysterectomy +/- Ovaries ☐
- ☐ Joint Replacement (knee/hip) ☐
- ☐ Pacemaker ☐
- ☐ Stent ☐
- ☐ Tonsillectomy ☐
- ☐ Other _____

smart nutrition

Helping you look & feel 10 years younger

Symptom Survey

Rate each of the following symptoms based on your typical health profile for the past 30 days:

Point Scale:

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have it, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Use the TAB Key to move quickly through the fields

DIGESTIVE TRACT
- ☐ Nausea, vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Bloated feeling
- ☐ Belching, passing gas
- ☐ Heartburn
- ☐ Intestinal/stomach pain

Total 0

EARS
- ☐ Itchy ears
- ☐ Earaches, ear infections
- ☐ Drainage from ear
- ☐ Ringing in ears, hearing loss

Total 0

EMOTIONS
- ☐ Mood Swings
- ☐ Anxiety, fear, nervousness
- ☐ Anger, irritability, aggressiveness
- ☐ Depression

Total 0

ENERGY/ ACTIVITY
- ☐ Fatigue, sluggishness
- ☐ Apathy, lethargy
- ☐ Hyperactivity
- ☐ Restlessness

Total 0

EYES
- ☐ Watery or itchy eyes
- ☐ Swollen, reddened or sticky eyelids
- ☐ Bags or dark circles under eyes
- ☐ Blurred or tunnel vision (does not include near or farsightedness)

Total 0

HEAD
- ☐ Headaches
- ☐ Faintness
- ☐ Dizziness
- ☐ Insomnia

Total 0

HEART
- ☐ Irregular or skipped heartbeat
- ☐ Rapid or pounding heartbeat
- ☐ Chest pain

Total 0

JOINT/MUSCLE
- ☐ Pain or aches in joints
- ☐ Arthritis
- ☐ Stiffness or limitation of movement
- ☐ Pain or aches in muscles
- ☐ Feeling of weakness or tiredness

Total 0

LUNGS
- ☐ Chest congestion
- ☐ Asthma, bronchitis
- ☐ Shortness of breath
- ☐ Difficulty breathing

Total 0

MIND
- ☐ Poor memory
- ☐ Confusion, poor comprehension
- ☐ Poor concentration
- ☐ Poor physical coordination
- ☐ Difficulty making decisions
- ☐ Stuttering or stammering
- ☐ Slurred speech
- ☐ Learning disabilities

Total 0

MOUTH/THROAT
- ☐ Chronic coughing
- ☐ Gagging, frequent need to clear throat
- ☐ Sore throat, hoarseness, loss of voice
- ☐ Swollen or discolored tongue, gums, lips
- ☐ Canker sores

Total 0

NOSE
- ☐ Stuffy nose
- ☐ Sinus problems
- ☐ Hay fever
- ☐ Sneezing attacks
- ☐ Excessive mucus formation

Total 0

SKIN
- ☐ Acne
- ☐ Hives, rashes, dry skin
- ☐ Hair loss
- ☐ Flushing, hot flashes
- ☐ Excessive sweating

Total 0

WEIGHT
- ☐ Binge eating/drinking
- ☐ Craving certain foods
- ☐ Excessive weight
- ☐ Compulsive eating
- ☐ Water retention
- ☐ Underweight

Total 0

OTHER
- ☐ Frequent illness
- ☐ Frequent or urgent urination
- ☐ Genital itch or discharge

Total 0

GRAND Total 0

SUBMIT to Ruth