

Nutritional Assessment Questionnaire 1.5

Name: _____

Date: ____/____/____

Birth Date: _____

Gender: _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

PART I Read the following questions and circle the number that applies:

- KEY:** 0 = Do not consume or use
 1 = Consume or use 2 to 3 times monthly
 2 = Consume or use weekly
 3 = Consume or use daily

DIET

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

LIFESTYLE

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

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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| 25. 0 1 Antacids | 39. 0 1 Diuretics |
| 26. 0 1 Antianxiety medications | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics | 41. 0 1 Estrogen or progesterone (natural) |
| 28. 0 1 Anticonvulsants | 42. 0 1 Heart medications |
| 29. 0 1 Antidepressants | 43. 0 1 High blood pressure medications |
| 30. 0 1 Antifungals | 44. 0 1 Laxatives |
| 31. 0 1 Aspirin/Ibuprofen | 45. 0 1 Recreational drugs |
| 32. 0 1 Asthma inhalers | 46. 0 1 Relaxants/Sleeping pills |
| 33. 0 1 Beta blockers | 47. 0 1 Testosterone (natural or prescription) |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication |
| 35. 0 1 Chemotherapy | 49. 0 1 Acetaminophen (Tylenol) |
| 36. 0 1 Cholesterol lowering medications | 50. 0 1 Ulcer medications |
| 37. 0 1 Cortisone/steroids | 51. 0 1 Sildenafil citrate (Viagra) |
| 38. 0 1 Diabetic medications/insulin | |

PART II (See key at bottom of page)

Section 1

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness after meals | 69. 0 1 2 3 Black or tarry colored stools |
| | 70. 0 1 2 3 Undigested food in stool |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 2

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

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| <p>99. 0 1 2 3 Food allergies
 100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
 101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
 102. 0 1 2 3 Pulse speeds after eating
 103. 0 1 2 3 Airborne allergies
 104. 0 1 2 3 Experience hives
 105. 0 1 2 3 Sinus congestion, "stuffy head"
 106. 0 1 2 3 Crave bread or noodles
 107. 0 1 2 3 Alternating constipation and diarrhea</p> | <p>108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)
 109. 0 1 2 3 Wheat or grain sensitivity
 110. 0 1 2 3 Dairy sensitivity
 111. 0 1 Are there foods you could not give up (0=no, 1=yes)
 112. 0 1 2 3 Asthma, sinus infections, stuffy nose
 113. 0 1 2 3 Bizarre vivid dreams, nightmares
 114. 0 1 2 3 Use over-the-counter pain medications
 115. 0 1 2 3 Feel spacey or unreal</p> |
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Section 4

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| <p>116. 0 1 2 3 Anus itches
 117. 0 1 2 3 Coated tongue
 118. 0 1 2 3 Feel worse in moldy or musty place
 119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
 120. 0 1 2 3 Fungus or yeast infections
 121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
 122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
 123. 0 1 2 3 Stools hard or difficult to pass
 124. 0 1 History of parasites (0=no, 1=yes)
 125. 0 1 2 3 Less than one bowel movement per day</p> | <p>126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
 127. 0 1 2 3 Stools are not well formed (loose)
 128. 0 1 2 3 Irritable bowel or mucus colitis
 129. 0 1 2 3 Blood in stool
 130. 0 1 2 3 Mucus in stool
 131. 0 1 2 3 Excessive foul smelling lower bowel gas
 132. 0 1 2 3 Bad breath or strong body odors
 133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
 134. 0 1 2 3 Cramping in lower abdominal region
 135. 0 1 2 3 Dark circles under eyes</p> |
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Section 5

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| <p>136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
 137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
 138. 0 1 History of stress fracture (0=no, 1=yes)
 139. 0 1 2 3 Bone loss (reduced density on bone scan)
 140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
 141. 0 1 2 3 Calf, foot or toe cramps at rest
 142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
 143. 0 1 2 3 Frequent fevers
 144. 0 1 2 3 Frequent skin rashes and/or hives
 145. 0 1 Herniated disc (0=no, 1=yes)
 146. 0 1 2 3 Excessively flexible joints, "double jointed"
 147. 0 1 2 3 Joints pop or click
 148. 0 1 2 3 Pain or swelling in joints
 149. 0 1 2 3 Bursitis or tendonitis</p> | <p>150. 0 1 History of bone spurs (0=no, 1=yes)
 151. 0 1 2 3 Morning stiffness
 152. 0 1 2 3 Nausea with vomiting
 153. 0 1 2 3 Crave chocolate
 154. 0 1 2 3 Feet have a strong odor
 155. 0 1 2 3 History of anemia
 156. 0 1 2 3 Whites of eyes (sclera) blue tinted
 157. 0 1 2 3 Hoarseness
 158. 0 1 2 3 Difficulty swallowing
 159. 0 1 2 3 Lump in throat
 160. 0 1 2 3 Dry mouth, eyes and/or nose
 161. 0 1 2 3 Gag easily
 162. 0 1 2 3 White spots on fingernails
 163. 0 1 2 3 Cuts heal slowly and/or scar easily
 164. 0 1 2 3 Decreased sense of taste or smell</p> |
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<p>KEY: 0=No, symptom does not occur 1=Yes, minor or mild symptom, rarely occurs (monthly)</p>	<p>2=Moderate symptom, occurs occasionally (weekly) 3=Severe symptom, occurs frequently (daily)</p>
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Section 6

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

Section 7

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

Section 8

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|--------------|---|--------------|--|
| 186. 0 1 2 3 | Muscles become easily fatigued | 200. 0 1 2 3 | Can hear heart beat on pillow at night |
| 187. 0 1 2 3 | Feel exhausted or sore after moderate exercise | 201. 0 1 2 3 | Whole body or limb jerk as falling asleep |
| 188. 0 1 2 3 | Vulnerable to insect bites | 202. 0 1 2 3 | Night sweats |
| 189. 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs | 203. 0 1 2 3 | Restless leg syndrome |
| 190. 0 1 2 3 | Enlarged heart or congestive heart failure | 204. 0 1 2 3 | Cracks at corner of mouth (Cheilosis) |
| 191. 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes) | 205. 0 1 2 3 | Fragile skin, easily chaffed, as in shaving |
| 192. 0 1 2 3 | Ringing in the ears (Tinnitus) | 206. 0 1 2 3 | Polyps or warts |
| 193. 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. 0 1 2 3 | MSG sensitivity |
| 194. 0 1 2 3 | Depressed | 208. 0 1 2 3 | Wake up without remembering dreams |
| 195. 0 1 2 3 | Fear of impending doom | 209. 0 1 2 3 | Small bumps on back of arms |
| 196. 0 1 2 3 | Worrier, apprehensive, anxious | 210. 0 1 2 3 | Strong light at night irritates eyes |
| 197. 0 1 2 3 | Nervous or agitated | 211. 0 1 2 3 | Nose bleeds and/or tend to bruise easily |
| 198. 0 1 2 3 | Feelings of insecurity | 212. 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. 0 1 2 3 | Heart races | | |

Section 9

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|--------------|--|--------------|--|
| 213. 0 1 2 3 | Tend to be a "night person" | 226. 0 1 2 3 | Arthritic tendencies |
| 214. 0 1 2 3 | Difficulty falling asleep | 227. 0 1 2 3 | Crave salty foods |
| 215. 0 1 2 3 | Slow starter in the morning | 228. 0 1 2 3 | Salt foods before tasting |
| 216. 0 1 2 3 | Tend to be keyed up, trouble calming down | 229. 0 1 2 3 | Perspire easily |
| 217. 0 1 2 3 | Blood pressure above 120/80 | 230. 0 1 2 3 | Chronic fatigue, or get drowsy often |
| 218. 0 1 2 3 | Headache after exercising | 231. 0 1 2 3 | Afternoon yawning |
| 219. 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. 0 1 2 3 | Afternoon headache |
| 220. 0 1 2 3 | Clench or grind teeth | 233. 0 1 2 3 | Asthma, wheezing or difficulty breathing |
| 221. 0 1 2 3 | Calm on the outside, troubled on the inside | 234. 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. 0 1 2 3 | Chronic low back pain, worse with fatigue | 235. 0 1 2 3 | Tendency to sprain ankles or "shin splints" |
| 223. 0 1 2 3 | Become dizzy when standing up suddenly | 236. 0 1 2 3 | Tendency to need sunglasses |
| 224. 0 1 2 3 | Difficulty maintaining manipulative correction | 237. 0 1 2 3 | Allergies and/or hives |
| 225. 0 1 2 3 | Pain after manipulative correction | 238. 0 1 2 3 | Weakness, dizziness |

Section 10

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|--------------|---|--------------|---|
| 239. 0 1 | Height over 6' 6" (0=no, 1=yes) | 245. 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. 0 1 2 3 | Decreased libido |
| 241. 0 1 2 3 | Increased libido | 247. 0 1 2 3 | Excessive thirst |
| 242. 0 1 2 3 | Splitting type headache | 248. 0 1 2 3 | Weight gain around hips or waist |
| 243. 0 1 2 3 | Memory failing | 249. 0 1 2 3 | Menstrual disorders |
| 244. 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. 0 1 | Delayed sexual development (after age 13) (0=no, 1=yes) |
| | | 251. 0 1 2 3 | Tendency to ulcers or colitis |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 11

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|---|---|
| 252. 0 1 2 3 Sensitive/allergic to iodine | 260. 0 1 2 3 Mentally sluggish, reduced initiative |
| 253. 0 1 2 3 Difficulty gaining weight, even with large appetite | 261. 0 1 2 3 Easily fatigued, sleepy during the day |
| 254. 0 1 2 3 Nervous, emotional, can't work under pressure | 262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet) |
| 255. 0 1 2 3 Inward trembling | 263. 0 1 2 3 Constipation, chronic |
| 256. 0 1 2 3 Flush easily | 264. 0 1 2 3 Excessive hair loss and/or coarse hair |
| 257. 0 1 2 3 Fast pulse at rest | 265. 0 1 2 3 Morning headaches, wear off during the day |
| 258. 0 1 2 3 Intolerance to high temperatures | 266. 0 1 2 3 Loss of lateral 1/3 of eyebrow |
| 259. 0 1 2 3 Difficulty losing weight | 267. 0 1 2 3 Seasonal sadness |

Section 12 – Men Only

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|--|---|
| 268. 0 1 2 3 Prostate problems | 272. 0 1 2 3 Waking to urinate at night |
| 269. 0 1 2 3 Difficulty with urination, dribbling | 273. 0 1 2 3 Interruption of stream during urination |
| 270. 0 1 2 3 Difficult to start and stop urine stream | 274. 0 1 2 3 Pain on inside of legs or heels |
| 271. 0 1 2 3 Pain or burning with urination | 275. 0 1 2 3 Feeling of incomplete bowel evacuation |
| | 276. 0 1 2 3 Decreased sexual function |

Section 13 – Women Only

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|---|--|
| 277. 0 1 2 3 Depression during periods | 287. 0 1 2 3 Breast fibroids, benign masses |
| 278. 0 1 2 3 Mood swings associated with periods (PMS) | 288. 0 1 2 3 Painful intercourse (dysparenia) |
| 279. 0 1 2 3 Crave chocolate around periods | 289. 0 1 2 3 Vaginal discharge |
| 280. 0 1 2 3 Breast tenderness associated with cycle | 290. 0 1 2 3 Vaginal dryness |
| 281. 0 1 2 3 Excessive menstrual flow | 291. 0 1 2 3 Vaginal itchiness |
| 282. 0 1 2 3 Scanty blood flow during periods | 292. 0 1 2 3 Gain weight around hips, thighs and buttocks |
| 283. 0 1 2 3 Occasional skipped periods | 293. 0 1 2 3 Excess facial or body hair |
| 284. 0 1 2 3 Variations in menstrual cycles | 294. 0 1 2 3 Hot flashes |
| 285. 0 1 2 3 Endometriosis | 295. 0 1 2 3 Night sweats (in menopausal females) |
| 286. 0 1 2 3 Uterine fibroids | 296. 0 1 2 3 Thinning skin |

Section 14

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| 297. 0 1 2 3 Aware of heavy and/or irregular breathing | 302. 0 1 2 3 Ankles swell, especially at end of day |
| 298. 0 1 2 3 Discomfort at high altitudes | 303. 0 1 2 3 Cough at night |
| 299. 0 1 2 3 "Air hunger" or sigh frequently | 304. 0 1 2 3 Blush or face turns red for no reason |
| 300. 0 1 2 3 Compelled to open windows in a closed room | 305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion |
| 301. 0 1 2 3 Shortness of breath with moderate exertion | 306. 0 1 2 3 Muscle cramps with exertion |

Section 15

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| 307. 0 1 2 3 Pain in mid-back region | 310. 0 1 2 3 Cloudy, bloody or darkened urine |
| 308. 0 1 2 3 Puffy around the eyes, dark circles under eyes | 311. 0 1 2 3 Urine has a strong odor |
| 309. 0 1 History of kidney stones (0=no, 1=yes) | |

Section 16

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| 312. 0 1 2 3 Runny or drippy nose | 317. 0 1 2 3 Never get sick (0 = sick only 1 or 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) |
| 313. 0 1 2 3 Catch colds at the beginning of winter | 318. 0 1 2 3 Acne (adult) |
| 314. 0 1 2 3 Mucus producing cough | 319. 0 1 2 3 Itchy skin (Dermatitis) |
| 315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 320. 0 1 2 3 Cysts, boils, rashes |
| 316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year) | 321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe) |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)