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# Nutrition Assessment Form

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My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges. **To enhance your scheduled consult time, please have this form back to me at least 1 day prior to your appointment. If possible, you can scan and email the form to HealthyLifestylesPLLC@gmail.com.**

Name _____Today's date_____

Address: _____City:_____State:_____Zip:_____

E-mail Address: _____ Fax Number: (____) _____- _____

Home Phone: (____) _____- _____ Work: (____) _____- _____ Cell: (____) _____- _____

Birthdate ___/ ____/ _____ Age: ____ Place of Birth: _____
month day year city/town (and country if not in US)

Occupation: _____ Referred by: _____

Height: ____'_____" Weight: ___ Sex: ____ Desired Weight: ___ Last Age at Desired Weight____

Highest Adult Weight: ____ What Age? ____ Lowest Adult Weight: ____ What Age?: ____

Have you ever dieted? ☐Yes ☐No If Yes, how many times in your adult life? ____

Which diet(s) worked: _____

1. **Please rank current/ ongoing problems by priority and fill in the other boxes as completely as possible:**

| DESCRIBE PROBLEM | MILD/ MODERATE/ | TREATMENT | SUCCESS |
|---|---|---|---|
| Example: Post Nasal Drip | Moderate | Elimination Diet | Moderate |
| a. | | | |
| b. | | | |
| c. | | | |
| d. | | | |
| e. | | | |

**2. Please check appropriate box:**

__African American __Hispanic __Mediterranean __Asian
__Native American __Caucasian __North European __Other_____

**3. Weight and Eating History:**

Please indicate the age/date that your difficulties with food, weight and eating began, which behaviors (restricting, binge eating, emotional eating, purging, exercising, dieting, weight management programs you used and the resulting weight change you experienced.

**Age/Date when problems began:** **Behavior/Treatment** **Weight Change**

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

**Other comments:** _____

**4. Past Medical and Surgical History:**

| 3. **ILLNESSES** | **WHEN** | **COMMENTS** |
|---|---|---|
| a. Anemia (type) | | |
| b. Arthritis | | |
| c. Asthma | | |
| d. Bronchitis | | |
| e. Cancer | | |
| f. Chronic Fatigue Syndrome | | |
| g. Crohn's Disease or Ulcerative Colitis | | |
| h. Diabetes | | |
| i. Emphysema | | |
| j. Epilepsy, Convulsions or Seizures | | |
| k. Gallstones | | |
| l. Gout | | |
| m. Heart Attack/ Angina | | |
| n. Heart Failure | | |
| o. Hepatitis | | |
| p. High Blood Fats (cholesterol, triglycerides) | | |
| q. High Blood Pressure (hypertension) | | |
| r. Irritable Bowel | | |
| s. Kidney Stones | | |
| t. Mononucleosis | | |
| u. Pneumonia | | |
| v. Sinusitis | | |
| w. Sleep Apnea | | |
| x. Stroke | | |
| y. Thyroid Disease | | |
| z. Other (describe) | | |

| | | |
|---|---|---|
| **INJURIES** | | |
| ab. Back Injury | | |
| ac. Broken Bones | | |
| ad. Head Injury | | |
| ae. Neck Injury | | |
| af. Other (acute) ex: sprained muscle | | |
| ag. Other (chronic) ex: bad knees | | |
| **DIAGNOSTIC STUDIES** | | |
| ai. Bone Scan | | |
| aj. CAT Scan | | |
| ak. EKG | | |
| al. MRI | | |
| am. Upper/Lower GI Series | | |
| an. Other (describe) | | |
| **OPERATIONS** | | |
| ao. Dental Surgery | | |
| ap. Gallbladder | | |
| aq. Hysterectomy | | |
| ar. Tonsillectomy | | |
| as. Other (describe) | | |

## MEDICATIONS:

5. **What medications are you taking now?** Please also include non-prescription drugs you take daily/regularly.

| Medication Name | Purpose | Dosage | Start Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

6. **Do you take any other over the counter medications on an occasional basis?** ___No ___Yes
   If yes, which ones? _____
   _____

7. **How many times have you taken antibiotics as an infant or child?**
   ___Less than 5 times ___More than 5 times ___More than 10 times ___So many times I lost count
   Reason: _____

8. **As an adult, how often do you take antibiotics?**
   ___Never ___Once a year (on average) ___1-3 times a year (on average)
   ___Greater than 3 times a year
   Why? _____

9. **Were you ever on antibiotics for a prolonged period of time?** ___No ___Yes
   If yes, explain: _____
   _____

10. **Fill in the chart below for how many times you have taken oral steroids. (ie. Cortisone, Prednisone etc.)**

| | Less than 5 times | Greater than 5 times | Greater than 10 times |
|---|---|---|---|
| **Infancy/Childhood** | | | |
| **Teen** | | | |
| **Adulthood** | | | |

11. **List all vitamins, minerals and other nutritional supplements that you are taking. Indicate unit (mg/IU) and form (ie. calcium carbonate vs. calcium lactate).**

| Vitamin/Herbal Supplements | Brand | How Many and When | Start Date |
|---|---|---|---|
| **1.** | | | |
| **2.** | | | |
| **3.** | | | |
| **4.** | | | |
| **5.** | | | |
| **6.** | | | |
| **7.** | | | |
| **8.** | | | |
| **9.** | | | |
| **10.** | | | |
| **11.** | | | |
| **12.** | | | |
| **13.** | | | |
| **14.** | | | |

****If you are being seen in person, please bring bottles with you to your appointment****

12. **Please indicate significant family medical history** (ex: cancer, diabetes, heart disease, etc.

Maternal Side:

_____
_____

Paternal Side:

_____
_____

13. **Are your parents living?** __No __Yes

If no, comment:

_____

**14. Did you have any health issues as a child?** __ No __Yes If yes, at what age? _____
Describe:

_____
_____
_____

**15. As a child, were there foods you avoided?** __No __Yes (please specify below)

| Food | Symptoms |
|---|---|
| Ex: Milk | Ex: Gas and diarrhea |
| | |
| | |
| | |

**16. Please mark in the chart below with information about recent bowel movements:**

| **Frequency:** | | **Color:** | |
|---|---|---|---|
| More than 3 times a day | | Dark Brown | |
| 2-3 times a day | | Medium Brown | |
| One time per day | | Very dark or black | |
| 4-6 times a week | | Greenish | |
| 2-3 times a week | | Blood is visible | |
| Once or fewer times a week | | Varies a lot | |
| Consistency: | | Yellow, light brown | |
| Soft and well formed | | Greasy, shiny appearance | |
| Often float | | | |
| Difficult to pass | | | |
| Diarrhea | | | |
| Thin, long or narrow | | | |
| Small and hard | | | |
| Loose, but not watery | | | |
| Alternating between hard and loose/watery | | | |

**17. Do you experience intestinal gas?** (check all that apply)
__present with pain __foul smell __little odor __excessive daily
__occasionally

**18. Do you experience anal itching?** __frequently __occasionally __rarely __never

**19. Do you experience any heartburn, chest pressure, or stomach pain?** __No __Yes
If yes, please list what you take anything for relief:

_____
_____

**WOMEN ONLY: (Questions 20-30)**

20. **Have you ever been pregnant?** __No __Yes
    If yes, please answer the following:
    a. Number of miscarriages ____
    b. Number of abortions _____
    c. Number of preemies _____
    d. Number of term births _____
    e. Birth weight of largest baby _____
    f. Birth weight of smallest baby _____
    g. Did you develop toxemia? ___No ___Yes
    h. Have you had any other problems with pregnancy? ___No ____Yes
       If yes, please describe:
       _____
       _____

21. **Age of first menses:**_____
22. **Date of last Pap Smear:**_____ Normal___ Abnormal___
23. **Date of last Mammogram:**_____ Normal___ Abnormal___
24. **Do you currently use contraception?** ___No ___Yes
    Type: _____
25. **Are you currently taking birth control pills?** ___No ___ Yes If yes, how long?_____
    If you are currently on the pill, please describe any physical or mental changes from before taking to now:
    _____
26. **Do you currently experience PMS?** (i.e. water retention, breast tenderness, irritability etc.)
    ___No ___Yes If yes, specify symptoms:
    _____
27. **Have you ever experience PMS in the past?** ___No ___Yes If yes, when? _____
28. **Are you still menstruating?** ___No ___Yes If yes, age at last period _____
29. **Are you experiencing menopause symptoms?** ___ No ___Yes
30. **Do you take:** ___Estrogen ___ Estrace ___ Premarin ___Other Please specify_____
31. **(Men Only): Do you have prostrate swelling?** ___No ___Yes
32. **Do you have urinary problems?** ___No ___Yes
    If yes, please specify: ___Nightly urination
    ___Frequent daytime urination
    ___Irregular
    ___Dribbling afterwards
    ___Frequent urge to urinate
    ___Difficulty urinating
    ___Burning sensation
    ___Hesitancy
    ___Feeling of incomplete emptying

**DENTAL:**

**33. Do you have amalgam (silver, black or grey) fillings? ___No ___Yes If yes, how many? _____**

**34. Have you ever had fillings replaced?** ___No ___Yes

If yes, how many ___ When? _____ With what material? _____

**35. Do you have root canals? ___No ___Yes If yes, how many? _____**

**Any problems? _____**

**36. Have you had any cavities in the last 2 years? ___No ___Yes If yes, how many____**

**37. Do your gums ever bleed? ___No ___Yes If yes, how often_____**

**38. Do you ever grind your teeth? ___No ___Yes**

**39. Do you have any artificial joints or implants anywhere in the body or mouth?** ___No ___Yes

**SOCIAL:**

**40. How well have things been going for you lately?**

| | Great | Good | Could be better | Not very good | Does not apply |
|---|---|---|---|---|---|
| **a. School** | | | | | |
| **b. Job** | | | | | |
| **c. Social life** | | | | | |
| **d. Close friends** | | | | | |
| **e. Sex** | | | | | |
| **f. Your attitude** | | | | | |
| **g. Boy/girlfriend** | | | | | |
| **h. Children** | | | | | |
| **i. Parents** | | | | | |
| **j. Spouse** | | | | | |

**41. With whom do you live? List age of children, if any.**

_____

_____

**42. What is the attitude of those close to you concerning your health?**

**___Supportive ___Not supportive ___Indifferent**

**43. Are you currently married, or have you ever been married? ___No ___Yes**

**If yes, when? _____ If yes, spouse's occupation? _____**

**44. Have you ever been separated or divorced? ___No ___Yes**

**If yes, when? _____**

**45. What are your hobbies and leisure activities?**

_____

**46. Describe previous jobs/work:**

_____

_____

47. **Have you lived outside of the United States?** ___No ___Yes If yes, where/when?
_____

48. **What is your total number of airline trips in the last year?** _____
**Estimated number in life:** _____ **How many out of the country** _____

49. **Have you experienced any major losses in your life?** ___**No** ___**Yes**
**If so, please comment:**
_____
_____

50. **Have you or your family recently experienced any major life changes (ie. Job change)?**
___**No** ___**Yes If yes, please comment:** _____
_____

51. **Have you ever had psychotherapy or counseling?** ___**No** ___**Yes**
**If yes, what kind?** _____ **When?** _____
**Additional comments:** _____
_____

**LIFESTYLE:**

52. **How important is religion (or spirituality) to you?**
___**Not at all important** ___**Somewhat important** ___**Extremely important**

53. **Do you meditate?** ___**Occasionally** ___**Often** ___**Never**

54. **How much control do you feel you have over your current state of health?**
**Rate 1-10 (no control-full control)** _____
**Comment:**
_____
_____

55. **How much time have you lost from work or school in the past year due to illness?**
___**0-2 days** ___**3-5 days** ___**6-14 days** ___**greater than 14 days**

56. **What is your usual bedtime?** _____ **Wake time?** _____

57. **How well do you sleep? (check all that apply)**
___**Adequate (sleep through the night)**
___**Wake up feeling well rested**
___**Trouble falling asleep**
___**Wake up still tired**
___**Trouble staying asleep**
**How many times do you wake up during the night?** ____

**58. Check off typical bedtime activities:**

**___Watch television**
**___Read a book**
**___Listen to music**
**___Bedtime snack**
**___Meditate**
**___Bath/Shower**
**___Drink alcohol**
**___Drink caffeinated beverage**
**___Other, please specify _____**

**59. Do you ever need to take a sleep aid? ___No ___Yes**
**If yes, which one/what dose/how often? _____**

**60. Do you exercise regularly now? ___No ___Yes**
**If no, have you in the past ___No ___Yes**
**If yes, how often? ___Once/week ___2 times/week ___3 times/week ___4 times/week +**
**Time per session: ___less than 15 minutes ___15-30 minutes ___30-45 minutes ___>45 min**

**61. What types of exercise do you currently do?**

**___Jogging**
**___Walking (not including dog walking)**
**___Weight training**
**___Water sports**
**___Aerobics**
**___Yoga**
**Other, please specify: _____**

**62. Do you get sun exposure? ___No ___Yes**
**___Daily ___Weekly How much per day/week_____**

**63. Do you wear sun block? ___No ___Yes**
**___Every time ___Occasionally**

**ALLERGY & TOXIC POTENTIAL:**

**64. Do you have any pets or farm animals? ___No ___Yes If yes, list _____**
**If yes, where do they live? ___Indoors ___Outdoors ___Both**

**65. Do odors such as perfume, cleaning solutions, smoke etc. affect you? ___No ___Yes**
**If yes, explain _____**

**66. Have you, to your knowledge, been exposed to toxic metals at your job or at home?**
**___No ___Yes: ___Lead ___Cadmium ___Arsenic ___Mercury ___Aluminum**
**Explain: _____**

**67. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?**
**___No ___Solvents ___Paints ___Pesticides ___Petrochemicals ___Coal**
**___Hydrocarbons ___Mold ___Other (specify)**
**_____**

**68. Do you know or have you recently lived in an older home (pre 1970s)? ___No ___Yes**
**If yes, how old is/was your home? _____ How long have/did you live there? _____**

**69. Have you ever lived or worked in a water damaged building? ___No ___Yes**
**If yes, when? _____ How long? _____**

**70. Have past activities/hobbies exposed you to photography chemicals, paints, glues or dyes?**
**___No ___Yes If yes, explain _____**

**71. How often do you wear dry cleaned clothing? _____**

**72. Do you have regular lawn care service? ___No ___Yes If yes, how often_____**

**73. Do you regularly spray for pests outdoors? ___No ___Yes If yes, how often_____**

**74. Do you use bug spray (outdoors) or insecticides (indoors) on a regular basis? ___No ___Yes**

**75. How often are you exposed to burning coal, bonfires, fire pits etc.? _____**

**76. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?**
**Currently: ___No ___Yes ___1-3 drinks per week ___4-6 ___7-10 ___10 or more**
**In the past: ___No ___Yes ___ 1-3 drinks per week ___4-6 ___7-10 ___10 or more**
**If you have quit, when? _____**

**77. Have you ever used tobacco? ___No ___Yes If yes, specify _____**
**If yes, number of years ___ Amount per day _____ Year quit _____**

**78. Are you now or were you ever regularly exposed to second hand smoke? ___No ___Yes**
**When? _____**

**79. Have you ever used recreational drugs? ___No ___Yes**
**If yes, specify age, type and amount: _____**

**DIETARY HABITS:**

**80. Please write down the number of times you may use the following behaviors and note how frequently you use them. (times/day or week)**

- **How often do you diet/fast/use diet pills or cut back the amount of food you eat? _____**
- **How often do you feel out of control eating large quantities of food? _____**
  **List foods you would eat: _____**
  **_____**
- **How often do you feel the need to remove food by vomiting after eating or binging? _____**
- **How often do you exercise? _____**
- **How often do you feel the need to exercise immediately after eating? _____**
- **How often do you use laxatives/diuretics after eating? How many? _____**
- **What percentage of your time do you spend thinking about food? _____**

- **How often do you wake up dreaming about food?** _____
- **How often do you crave specific foods?** _____
  **List foods:**

  _____
- **How often do you eat when you are sad, bored, nervous or angry?** _____
- **How often do you look in the mirror and dislike your body?** _____
- **How often do you weigh yourself?** _____
- **How often does your weight affect your mood?** _____
- **How often do you eat when you are hungry and stop when you are full?** _____
- **How often does your work/school schedule affect how you eat?** _____
- **How often do you feel guilty about eating?** _____
- **How often is your eating affected by friends and family members' comments?** _____
- **How often do you chew gum/eat candy?** _____
- **How often do you drink tea, coffee and/or soda?** _____
- **How often do you smoke?** _____

81. **What were/are your family's views or rules about:**
    - **Healthy eating** _____
    - **Healthy body weight** _____
    - **Dieting** _____
    - **Exercising** _____

82. **Who in your family has the same body shape and size as you? (Think about aunts, uncles, grandparents as well as parents and siblings.)** _____

    _____

83. **Who in your family eats the same way as you?** _____
84. **Who in your family has the same activity level as you?** _____
85. **Are you currently on a special diet (i.e. vegetarian, South Beach etc.)? ___No ___Yes**
    **If yes, how long and describe:**

    _____

    _____
86. **What time do you usually eat your meals? Breakfast time:** _____ **Lunch time:** _____
    **Dinner time:** _____ **Snack time:** _____ **Snack time:** _____ **Snack time:**_____

**87. Place a mark next to the food/drink that applies to a typical day of your current diet.**

| Usual Breakfast | | Usual Lunch | | Usual Dinner | | Usual Snacks | |
|---|---|---|---|---|---|---|---|
| None | | None | | None | | None | |
| Cereal | | Eat in cafeteria | | Pasta | | Nuts | |
| Wheat Bran | | Eat in restaurant | | Potato | | Fruit | |
| Oatmeal | | Leftovers | | Brown rice | | Vegetables | |
| Toast | | Meat sandwich | | White rice | | Pretzels | |
| Bagel | | Fish sandwich | | Beans (legumes) | | Potato chips | |
| Sweet Roll | | Lettuce (on sandwich) | | Fish | | Corn chips | |
| Donut | | Tomato | | Red Meat | | Crackers | |
| Eggs | | Salad | | Poultry | | Cheese | |
| Bacon/Sausage | | Salad Dressing | | Salad | | Cookies | |
| Fruit | | Soup | | Salad dressing | | Cake/Pastries | |
| Yogurt | | Fruit | | Green vegetables | | Nut butters | |
| Milk | | Yogurt | | Carrots | | Cereal | |
| Juice | | Milk | | Yellow vegetables | | Ice Cream | |
| Tea | | Juice | | Milk | | Trail mix | |
| Coffee | | Tea | | Juice | | Dried fruit | |
| Water | | Coffee | | Tea | | Other: | |
| Butter | | Water | | Coffee | | | |
| Margarine | | Regular soda | | Water | | | |
| Sugar | | Diet soda | | Regular soda | | | |
| Sweetener | | Butter | | Diet soda | | | |
| Leftovers | | Margarine | | Butter | | | |
| Others: | | Mayonnaise | | Margarine | | | |
| | | Sugar | | Sugar | | | |
| | | Sweetener | | Sweetener | | | |
| | | Other: | | Other: | | | |
| | | | | | | | |

**88. Do you currently or typically have any symptoms immediately after eating? (i.e. belching, fatigue, bloating, sneezing, hives etc.) ___No ___Yes If yes, are these symptoms associated with any food in particular? Explain (i.e. Milk-gas, diarrhea):**

**_____**

**_____**

**89. Do you feel you have delayed symptoms after eating certain foods such as: fatigue, muscle aches, sinus congestion etc.)? Delayed symptoms may not be evident for 24 hours or more after eating.**

**___No ___Yes If yes, specify: _____**

**_____**

**90. Do you feel much worse when you eat any of the following: (check all that apply)**

**___high fat foods**
**___refined sugar (junk food)**
**___high protein foods**
**___fried foods**
**___high carbohydrate foods (breads, pastas, potatoes)**
**___1 or 2 alcoholic drinks**
**___Other (specify) _____**

**91. Do you feel much better when you eat a lot of: (check all that apply)**

**___high fat foods**
**___refined sugar (junk food)**
**___high protein foods**
**___fried foods**
**___high carbohydrate foods (breads, pastas, potatoes)**
**___1 or 2 alcoholic drinks**
**___Other (specify) _____**

**92. Do you feel worse at certain times of the year? ___No ___Yes If yes, when? _____**
**How do you feel? _____**

**93. Do you feel better at certain times of the year? ___No ___Yes If yes, when? _____**
**How do you feel? _____**

**94. Average daily water intake in 8 oz glasses (not counting soda pop, coffee):**

___1-2 ___3-4 ___5-6 ___7-8 ___9-10
___Tap water ___Filtered tap water ___Spring Water ___Distilled ___Other _____

**95. How many times per week do you eat out? _____**

**96. Rate the type of restaurants you frequent in order of most to least often (1-5).**

___Fast Food
___Fine dining
___Cafe
___Coffee Shop (i.e. Corner Bakery)
___Casual Dining
___Breakfast (i.e. IHOP)
___Grocery store deli
___Health food store deli

**97. Are you the primary cook for your household?** ___No ___Yes If not, who is?
_____

**98. On a scale of 1(love it)-5(hate it), how much do you enjoy preparing/cooking food?**
_____

**100. Where do you do the bulk of your grocery shopping? _____**
**101. What percentage of your food intake is Organic? _____**
**102. Do you drink bottled water?** ___No ___Yes If yes, how many per day ___ What size_____

**Anything else you think we should know? This is the place where you can detail your main concerns and what your goals are in our working together:**

_____
_____
_____
_____
_____
_____
_____
_____
_____