whole family wellness

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# Nutrition Questionnaire

**Thank you for taking the time to fill out this nutrition questionnaire. This questionnaire is an important part of your, or your child's, initial consultation. Accurate completion of this form will ensure more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will assist your Nutritional Consultant in formulating the most appropriate nutrition plan.**

| Personal Information | |
|---|---|
| **Patient's Name:**_____ **Date of Birth:**_____ **Male** ○ **Female** ○ | |
| **Height:** | **Weight:** |
| **Body Frame:** | **Blood type (if known):** |
| **Form Completed by (include relation to patient):** | |
| **Name/Address of Primary Care Physician:** | |
| **Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any):** | |
| **Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any):** | |
| **Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any):** | |

**Please check appropriate box(es):**

| | | | |
|---|---|---|---|
| ☐ **African American** | ☐ **Hispanic** | ☐ **Mediterranean** | ☐ **Asian** |
| ☐ **Native American** | ☐ **Caucasian** | ☐ **Northern European** | ☐ **Other** _____ |



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holistic care for your body, mind, & spirit

| Health Concerns and History |
|---|
| **What are your main objectives for seeing a nutrition professional?** |
| **Describe onset and occurrence of health problems in detail:** |
| **How have you previously dealt with these concerns (doctors, self-care) and with what results?** |
| **Please briefly describe your, or your child's, health history (use additional sheet at the end of this document if necessary):** |
| **Have any other family members had similar problems?** ○ **Yes** ○ **No** **(If yes, describe):** |



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| Medication/Supplement History | | | |
|---|---|---|---|
| **Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):** | | | |
| **Supplement/Medication** | **Dose** | **Frequency** | **Date Started** |
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| Medication/Supplement History | |
|---|---|
| **Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):** | |
| **Supplement/Medication** | **Reason Stopped** |
| | |
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## Dietary History

**Do you, or your child, have any food allergies or food intolerances that you know of? Please list them, if known:**

**Describe any history of dieting or disordered eating (yo-yo dieting, bingeing, anorexia, bulimia, etc.):**

**Do you, or your child, have any food cravings or addictions (i.e. sugar, breads, ice cream, etc.) Please describe:**

**Are you, or your child, currently following any special diet? Please check off which one(s):**

- ☐ No restrictions
- ☐ Gluten Free
- ☐ Casein Free
- ☐ Yeast Free
- ☐ Feingold
- ☐ Body Ecology Diet
- ☐ Raw Diet
- ☐ Ketogenic
- ☐ Vegetarian
- ☐ Specific Carbohydrate Diet
- ☐ Other (please describe):

## Digestive History

**How often do you have a bowel movement?**

**What is your stool like (check all that apply)?**

- ☐ Well-formed
- ☐ Mucousy
- ☐ Loose, falls apart
- ☐ Watery
- ☐ Small, hard pieces
- ☐ Greasy, floats
- ☐ Bloody
- ☐ Thin and long, ribbons
- ☐ Foul-smelling
- ☐ Painful
- ☐ Lots of undigested food particles
- ☐ Medium/dark brown
- ☐ Yellow/light brown
- ☐ Greenish
- ☐ Very dark or black
- ☐ Other (please describe):

**Do you have heartburn or reflux?** ◯ Yes ◯ No **(If yes, please list any treatments):**

**Do you have frequent gas or belly bloating?** ◯ Yes ◯ No **(If yes, please describe):**

**Do you have any abdominal pain?** ◯ Yes ◯ No **(If yes, please describe how often and nature of pain):**



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## Stress

**Please describe areas of stress in your, or your child's, life (family, work, relationships, school, etc.):**

**On a scale of 1-10, how would you rate your, or your child's, stress? (10 being the most stressed):**

## Sleep History

**How many hours of sleep do you, or your child, get every day?**

**What time do you, or your child, typically fall asleep at night?**

**What time do you, or your child, typically wake up?**

**Do you, or your child, need an alarm clock to wake up in the morning?** ○ Yes ○ No

**Do you, or your child, feel refreshed upon waking up in the morning?** ○ Yes ○ No

**Describe the quality of your, or your child's, sleep?**

## Environmental Exposures

**Are you, or your child, exposed to any of the following:**

- ☐ Tap water
- ☐ Air pollution
- ☐ Cosmetics
- ☐ Food & Chemical residues
- ☐ Amalgam Fillings
- ☐ Perfumes/Fragrances
- ☐ Tobacco
- ☐ Chemical Cleaning supplies
- ☐ Artificial Sweeteners (NutraSweet, Equal, etc.)
- ☐ OTC Medicines (Aspirin, Tylenol, etc.)
- ☐ Other (please describe):



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## Other Concerns

**Do you have any other concerns that you would like to mention? Please describe:**

## For Pediatric Clients Only

**Please describe pregnancy and birth:**

**Was your child fed anything other than breast milk during his/her first 6 months of life? ◯ Yes ◯ No**
**If yes, which foods?**

**Did your child receive formula? ◯ Yes ◯ No**
**If yes, which type of formula (cow's milk, soy, etc.)?**

**Does your child have sensory issues surrounding food (i.e., will only eat foods of certain textures, colors, etc.)?**
**◯ Yes ◯ No If yes, please describe:**

**Would you consider your child a "picky eater"? ◯ Yes ◯ No If yes, please describe:**



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## Additional Space

**Please use this area when additional space was needed elsewhere in the questionnaire.**



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