Patient Questionnaire	Date:		
Name			
Preferred Name			
Date of Birth		Age:	Gender: ☐ M ☐ F
Genetic Background	☐ African American ☐ Native American ☐ Mediterranean	☐ Hispanic ☐ Caucasian ☐ Northern European	☐ Asian ☐ Other: _____
Primary Address			
City, State, Zip code			
Preferred Primary Phone	☐ Home ☐ Cell ☐ Work		
Secondary Phone	☐ Home ☐ Cell ☐ Work		
Fax			
Email Address			
Best way to contact?	☐ Email ☐ Phone Leave a message? ☐ Y ☐ N		

Primary Physician	*Name:*	*City:*
	Email:	*Phone:*
Other Pertinent Provider	*Name:*	*City:*
	Email:	*Phone:*
Other Pertinent Provider	*Name:*	*City:*
	Email:	*Phone:*

Referred by:_____

Goals & Concerns

What do you hope to achieve in your visit?

List your three main health/nutrition concerns:

1.

2.

3.

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

What makes you feel worse?

Comments:

Allergy Information

Please list **food** allergies:

Please list **non-food** allergies including medications/supplements:

Please list **environmental** allergies:

What type of allergic symptoms do you experience?

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, mental illness or addiction, etc.*

Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Known Genetic Disorders:	
Comments:	

Medical History

Please check health conditions that your doctor has diagnosed and provide the date of onset

Gastrointestinal	**Now**	**Past**	**Inflammatory / Autoimmune**	**Now**	**Past**
Celiac Disease			Chronic Fatigue Syndrome		
Crohn's Disease					
Gastric or Peptic Ulcer Disease			Epstein-Barr Virus		
GERD/heartburn/reflux			Graves Disease		
Irritable Bowel Syndrome			Gout		
Liver Disease			Hashimoto's thyroiditis		
Small Intestinal Bacterial Overgrowth			Herpes		
			Lupus SLE		
Ulcerative Colitis			Poor Immune Function (frequent infection)		
Other:					
			Rheumatoid Arthritis		
Respiratory	**Now**	**Past**	Other:		
Asthma			**Musculoskeletal / Pain**	**Now**	**Past**
Bronchitis					
Chronic Sinusitis			Chronic Pain		
Emphysema			Fibromyalgia		
Pneumonia			Migraines		
Sleep Apnea			Osteoarthritis		
Tuberculosis			Other:		
Other:					

Cardiovascular	Now	Past
Atherosclerosis		
Elevated cholesterol		
Heart attack		
High blood pressure		
Irregular heart beat		
Mitral Valve Prolapse		
Other :		

Neurological/Brain	Now	Past
ADD/ADHD		
Alzheimer's disease		
ALS		
Anorexia		
Anxiety		
Aspergers		
Autism		
Bulimia		
Eating disorder, Unspecified		
Memory problems		
Parkinson's disease		
Seizures		
Stroke		
Other		

Urinary / Gynecological *For men and women*	Now	Past
Kidney Stones		
Prostate problems		
Urinary tract infection (UTI)		
Yeast overgrowth/infection		
Other:		

Cancer	Now	Past
Cancer *(please describe type and treatment)*		

Metabolic / Endocrine	Now	Past
Diabetes - Type 1 - Type 2		
Hypoglycemia		
Hypothyroidism (low thyroid)		
Hyperthyroidism (over active thyroid		
Infertility		
Metabolic Syndrome (pre-diabetes, insulin resistance)		
Polycystic Ovarian Syndrome (PCOS)		
Other:		

Dermatological	Now	Past
Acne		
Eczema		
Psoriasis		
Rosacea		
Skin Rash		
Other:		

Describe any additional medical or health problem concerns:

Oral History

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N *If yes, how many?*

Do you have any? ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have? ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems ☐ TMJ

☐ Oral thrush ☐ Swallowing problems ☐ Other, *please describe:*

Surgeries/Hospitalizations

Please list any previous injuries, surgeries, and hospitalizations; provide the date and your age, if known.

Diagnostic Studies

Please list any diagnostic studies (example: CT scan, MRI, bone density, colonoscopy, etc, and provide data and age if known).

Birth History

Your Birth: ☐ Natural/Vaginal ☐ C-Section ☐ Unknown

Were you breastfed as an infant? ☐ Y ☐ N

How would you rate your health as a child? ☐ Good ☐ Fair ☐ Poor

Medications & Supplements

*Please list all **prescription medications** and **nutritional supplements, herbs/botanicals** you are currently taking with the year started. Use a separate sheet if needed.*

MEDICATION NAME	DOSE	FREQUENCY	REASON

SUPPLEMENT NAME	DOSE	FREQUENCY	REASON

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged use or regular use of opioid pain killers? ☐ Y ☐ N

Have you had prolonged or regular use of PPI's or acid-blocking drugs (Tagamet) ? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y ☐ N

Nutrition History

Have you ever had a nutrition consultation? ☐ Y ☐ *N If yes, date & describe outcome:*

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N *Please describe:*

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N *Please describe:*

Do you avoid any particular foods? ☐ Y ☐ N *Please describe:*

Height:	Current weight:	Weight 1 year ago:	Usual Weight :
Desired/goal weight:		Waist (inches):	Hip (inches):

Have you had any recent history of weight loss or weight gain? *If yes, please describe.*

Does your weight affect how you feel about yourself ? ☐ Y ☐ N *Please comment :*

Number of meals eaten per day : ☐ 1 meal per day ☐ 2 meals per day ☐ 3 meals per day

Number of snacks eaten per day: ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ > 3?

What % of meals do you eat out per week? ☐ >75% ☐ 50-75% ☐ 25-50% ☐ < 25%

Meal most often eaten out: ☐ Breakfast ☐ Lunch ☐ Dinner

Types of eating establishments most often frequented:

Do you avoid any particular foods or beverages? If yes, describe what and why :

What are your comfort foods ?

Do you crave any foods?

Are there special textures you prefer? Or avoid certain textures for a particular reason? *Please describe:*

What is your average daily water consumption (8 ounce glass)? ☐ 6-8 ☐ 4-6 ☐ 2-4 ☐ <2

Check all the factors that apply to your eating habits and lifestyle:

- ☐ Fast eater
- ☐ Erratic eating patterns
- ☐ Eat too much/overeat
- ☐ Late night eating
- ☐ Rely on convenience items
- ☐ Associate symptoms with eating
- ☐ Negative relationship with food
- ☐ Dislike healthy food
- ☐ Organic food is important to me
- ☐ Love to eat
- ☐ Love to cook
- ☐ Family members have different dietary needs
- ☐ Live or often eat alone
- ☐ Time constraints
- ☐ Drink too much alcohol
- ☐ Addicted to sugar/sweets
- ☐ Eat too many processed carbs (breads, pastas, chips, etc.)
- ☐ Struggle with eating issues
- ☐ Emotional eating
- ☐ Eat fast food frequently
- ☐ Poor snack choices
- ☐ Do not plan meals or menus
- ☐ Travel frequently
- ☐ Confused about nutrition advice

Please note any additional comments about your nutrition/eating habits :

_____

_____

_____

_____

Lifestyle

Do you engage in moderate cardiovascular physical activity for a minimum duration of 20 minutes at least 3 days a week? *For example: brisk walking, jogging, hiking, cardio exercise classes, cycling* ☐ Y ☐ N

ACTIVITY	**TYPE/INTENSITY** *(low-moderate-high)*	**# OF DAYS PER WEEK**	**DURATION***(minutes)*
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Note any problems that limit your physical activity.

Do you smoke? ☐ Y ☐ N	Do you chew tobacco? ☐ Y ☐ N	How many years?	Packs per day?	Secondhand smoke exposure? ☐ Y ☐ N
Do you currently use any of the following (i.e. marijuana, cocaine, crack, heroin, speed, etc)? ☐ Y ☐ N		If yes, please describe the type of drugs?		How often you use them ?

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Work_____ ☐ Family____ ☐ Social____ ☐ Finances____ ☐ Health_____ ☐ Other_____

Excess stress in your life? ☐ Y ☐ N	Do you easily handle stress? ☐ Y ☐ N
How do you handle stress, what relaxes you?	
Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ Unsure	Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night during the week? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+	Average number of hours you sleep per night on weekends? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+
Trouble falling asleep? ☐ Y ☐ N	Rested upon waking? ☐ Y ☐ N
Do you wake up during the night? ☐ Y ☐ N *If yes, how many times?*	
How would you rate the overall quality of your sleep? ☐ 1 *Low* ☐ 2 ☐ 3 ☐ 4 ☐ 5 *High*	

Environmental History

Do you experience or have you been diagnosed with chemical sensitivities? ☐ Y ☐ N

If yes, please describe symptoms.

What is your occupation?

Are you exposed regularly to any of the following? *Check all that apply:*

☐ Aluminum cookware
☐ Auto exhaust/fumes
☐ Chemicals
☐ Cigarette smoke
☐ Cosmetics: nail polish / hair dyes /perfumes
☐ Dry-cleaned clothes
☐ Fertilizers
☐ Heavy metals
☐ Mold
☐ Paint fumes
☐ Pesticides
☐ Pet dander
☐ Other

Please describe any significant past exposure to harmful chemicals/substances.

Readiness Assessment

What do you think would make the most difference in your overall health?

In order to improve your health, how willing are you to: *Rate on a scale of 5 (very willing) to 1 (not willing)*

Significantly modify your diet	☐5 ☐4 ☐3 ☐2 ☐1
Keep a record of everything you eat each day	☐5 ☐4 ☐3 ☐2 ☐1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐5 ☐4 ☐3 ☐2 ☐1
Engage in regular exercise/physical activity	☐5 ☐4 ☐3 ☐2 ☐1
Practice a daily relaxation technique	☐5 ☐4 ☐3 ☐2 ☐1
Take nutritional supplements as recommended	☐5 ☐4 ☐3 ☐2 ☐1
Have periodic lab tests to assess your progress	☐5 ☐4 ☐3 ☐2 ☐1

Comments:

Digestive History

Name _____Date_____

DIRECTIONS: This questionnaire asks you to assess how you have been feeling **during the last four months**. This information will help you keep track of how your physical, mental and emotional states respond to changes you make in your eating habits, priorities, supplement program, social and family life, level of physical activity and time spent on personal growth. All information is held in strict confidence. Take all the time you need to complete this questionnaire.

For each question, circle the number that best describes your symptoms:

0 = No or Rarely-You have never experienced the symptom or the symptom is familiar to you but you perceive it as insignificant. (monthly or less)

1 = Occasionally-Symptom comes and goes and is linked in your mind to stress, diet, fatigue or some identifiable trigger

4 = Often-Symptom occurs 2-3 times per week and/or with a frequency that bothers you enough that you would like to do something about it

8 = Frequently-Symptom occurs 4 or more times per week and/or you are aware of the symptom every day, or it occurs with regularity on a monthly or cyclical basis

Section A	**No/Rarely**	**Occasionally**	**Often**	**Frequently**	
1. Indigestion, food repeats on you after you eat	0	1	4	8	
2. Excessive burping, belching and/or bloating following meals	0	1	4	8	
3. Stomach spasms and cramping during or after eating	0	1	4	8	
4. A sensation that food just sits in your stomach creating uncomfortable fullness, pressure and bloating during or after a meal	0	1	4	8	
5. Bad taste in your mouth	0	1	4	8	
6. Small amounts of food fill you up immediately	0	1	4	8	
7. Skip meals or eat erratically because you have no appetite.	0	1	4	8	
TOTAL POINTS					

Section B	No/Rarely	Occasionally	Often	Frequently	
1. Strong emotions, or the thought or smell of food aggravates your stomach or makes it hurt	0	1	4	8	
2. Feel hungry an hour or two after eating a good-sized meal	0	1	4	8	
3. Stomach pain, burning and/or aching over a period of 1-4 hours after eating	0	1	4	8	
4. Stomach pain, burning and/or aching relieved by eating food; drinking carbonated beverages, cream or milk; or taking antacids	0	1	4	8	
5. Burning sensation in the lower part of your chest, especially when lying down or bending forward	0	1	4	8	
6. Digestive problems that subside with rest and relaxation	No			Yes	
7. Eating spicy and fatty (fried) foods, chocolate, coffee, alcohol, citrus or hot peppers causes your stomach to burn or ache	0	1	4	8	
8. Feel a sense of nausea when you eat	0	1	4	8	
9. Difficulty or pain when swallowing food or beverage	0	1	4	8	
TOTAL POINTS					
Section C	No/Rarely	Occasionally	Often	Frequently	
1. When massaging under your rib cage on your left side, there is pain, tenderness or soreness	0	1	4	8	
2. Indigestion, fullness or tension in your abdomen is delayed, occurring 2-4 hours after eating a meal	0	1	4	8	
3. Lower abdominal discomfort is relieved with the passage of gas or with a bowel movement	0	1	4	8	
4. Specific foods/beverages aggravate indigestion	0	1	4	8	
5. The consistency or form of your stool changes (e.g., from narrow to loose) within the course of a day	0	1	4	8	

6. Stool odor is embarrassing	0	1	4	8	
7. Undigested food in your stool	0	1	4	8	
8. Three or more large bowel movements daily	0	1	4	8	
9. Diarrhea (frequent loose, watery stool)	0	1	4	8	
10. Bowel movement shortly after eating (within 1 hr)	0	1	4	8	
TOTAL POINT					
Section D	No/Rarely	Occasionally	Often	Frequently	
1. Discomfort, pain or cramps in your colon (lower abdominal area)	0	1	4	8	
2. Emotional stress and/or eating raw fruits and vegetables causes abdominal bloating, pain, cramps or gas	0	1	4	8	
3. Generally constipated (or straining during bowel movements)	0	1	4	8	
4. Stool is small, hard and dry	0	1	4	8	
5. Pass mucus in your stool	0	1	4	8	
6. Alternate between constipation and diarrhea	0	1	4	8	
7. Rectal pain, itching or cramping	0	1	4	8	
8. No urge to have a bowel movement	No			Yes	
9. An almost continual need to have a bowel movement	No			Yes	
TOTAL POINTS					

Patient Narrative

Please write a summary of any information that will be helpful to me regarding your health and medical history or in your own words, ***tell me your story.***

My Symptom Questionnaire (MySQ)

Name: **Date:**

Rate each of the following symptoms based upon your typical health profile for the *Past 30 days*

0	1	2	3	4	5
Never	Rarely, Effect not severe	Occasionally, Effect not severe	Occasionally, Effect severe	Frequently, Effect not severe	Frequently, Effect severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
TOTAL____

NOSE
_____ Stuffy Nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucous
_____ Loss sense of smell
TOTAL____

NAILS
_____ Spoon shaped
_____ Brittle, cracking
_____ Discolored
_____ White spots
_____ Lines/Stripes
TOTAL____

HAIR
_____ Hair thinning
_____ Hair loss
_____ Loss of outer eyebrow hair
_____ Premature greying
_____ Easy hair pluckability
TOTAL____

SKIN
_____ Acne
_____ Hives, rashes
_____ Dry skin
_____ Bumps on back of arms
_____ Flushing
_____ Excessive sweating
TOTAL____

IMMUNE
_____ Colds
_____ Flu
_____ Chronic infections
TOTAL____

EYES
_____ Watery / itchy eyes
_____ Yellowing eyes
_____ Swollen, reddened, sticky eyelids
_____ Bags, dark circles
_____ Night vision problems
_____ Blurred vision
_____ Loss peripheral vision
TOTAL____

MOUTH/THROAT
_____ Chronic cough
_____ Gagging/throat clearing
_____ Sore throat
_____ Hoarseness
_____ Swollen/discolored tongue
_____ Burning tongue
_____ Coating on tongue
_____ Chewing problems
_____ Swallowing problems
_____ Canker sores
_____ Fever blisters
_____ Cracks corner of mouth
TOTAL____

HEART
_____ Irregular /skipped beats
_____ Rapid/pounding beats
_____ Chest pain
_____ TOTAL____

LUNGS
_____ Chest congestion
_____ Asthma or bronchitis
_____ Shortness of breath
_____ Difficulty breathing
TOTAL____

ENERGY/SLEEP
_____ Fatigue
_____ Lethargy
_____ Hyperactivity
_____ Insomnia
_____ Sleep disruptions
TOTAL____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing
_____ Hearing loss
TOTAL____

DIGESTIVE TRACT /GASTROINTESTINAL (GI)
_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Alternating diarrhea & constipation
_____ Bloating
_____ Belching
_____ Gas/flatulence
_____ Heartburn
_____ Upper GI pain
_____ Lower abdominal pain
TOTAL____

JOINTS/MUSCLE/BONE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness/limited movement
_____ Pain or aches in muscles
_____ Feeling of weakness or loss of strength
_____ Restless legs
_____ Bone pain
_____ Broken bones
TOTAL____

WEIGHT
_____ Underweight
_____ Overweight
_____ Obese
_____ Weight loss (>5-10 lbs)
_____ Weight gain (>5-10 lbs)
_____ Fluid retention
TOTAL____

NEURO	GENITOURINARY	EMOTIONS
_____ Frequent or urgent urination _____ Itching _____ Discharge _____ Incontinence TOTAL____	_____ Poor memory _____ Confusion _____ Poor concentration/"brain fog" _____ Poor physical coordination _____ Loss of balance _____ Tingling in hands or feet _____ Stuttering or stammering _____ Slurred speech TOTAL____	_____ Mood swings _____ Anxiety, worry, fear, nervousness _____ Anger, irritability, agitation _____ Depression TOTAL____ GRAND TOTAL____ Key: the higher the score, the greater the impact on the individual. 0-15 Fair 16-25 Moderate 26-50 Major >50 Severe

3-Day Food Journal

Name:

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Food Journal for three consecutive days including one weekend day.

- ***Do not change your eating habits at this time, as the purpose of this food record is to analyze your current diet***
- ***Record information as soon as possible after the food has been consumed***
- ***Describe all foods and beverages consumed as accurately and in as much detail as possible including estimated amounts, brand names, cooking method, etc.***
- ***Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.***
- ***Include any added items, for example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.***
- ***List all beverages and types, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.***
- ***Comment on any emotional or physical symptoms experienced including hunger level, stress, bloating, fatigue, adverse reaction(s) experienced, timing of adverse reactions, etc.***
- ***Include comments about eating habits and environment such as reasons for skipping a meal, when a meal was eaten at a restaurant, etc. and any additional details that may be important***
- ***Each day note all bowel movements, describe their consistency (regular, loose, firm, etc.), frequency, and any additional information***
- ***If you use an online food journal, provide me with your login information so it can be reviewed and be sure to include all necessary information described above.***

DATE: _____	**Food and Beverages**	**Comments or Symptoms**
BREAKFAST		
Time:_____		
SNACK		
LUNCH		

Time:_____		
SNACK		
DINNER **Time:_____**		

ELIMINATION **Description**	**Time: _____**	**Time: _____**	**Time: _____**

DATE: _____	**Food and Beverages**	**Comments or Symptoms**
BREAKFAST **Time:_____**		
SNACK		
LUNCH **Time:_____**		
SNACK		
DINNER **Time:_____**		

ELIMINATION **Description**	**Time: _____**	**Time: _____**	**Time: _____**

DATE: _____	**Food and Beverages**	**Comments or Symptoms**
BREAKFAST **Time:_____**		
SNACK		
LUNCH		

Time:_____			
SNACK			
DINNER			
Time:_____			
ELIMINATION	**Time: _____**	**Time: _____**	**Time: _____**
Description			

This form has been adapted from the intake form for the Integrative and Functional Nutrition Academy.