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HEALTH AND NUTRITION QUESTIONNAIRE

Please fill out this questionnaire to the best of your ability. It will help to assess your nutritional status and develop an individualized plan to meet your needs.

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

DATE OF BIRTH: _____ AGE: _____ EMAIL: _____ REFERRED BY: _____

MARRIED? _____ # OF KIDS _____ OCCUPATION: _____ WORK HOURS: _____

HEIGHT: _____ WEIGHT: _____ USUAL WEIGHT: _____ GOAL WEIGHT: _____

Do you have any of the following? Please check all that apply.

| Health Condition | Do you have? Yes or No Describe | Family History? List family member |
|---------------------------|---------------------------------|------------------------------------|
| Type 1 Diabetes | | |
| Type 2 Diabetes | | |
| High Blood Pressure | | |
| High Cholesterol | | |
| Heart Conditions | | |
| Thyroid Condition | | |
| Liver Conditions | | |
| Kidney Conditions | | |
| Digestive Disorders | | |
| HIV | | |
| Pregnant/ Nursing | | |
| Infertility/ Miscarriages | | |
| Cancer/ Chemotherapy | | |
| Chronic pain | | |
| Depression/ Anxiety | | |
| Eating Disorder | | |

Any other diagnosis not listed above: (Please specify) _____

Are you currently taking any *prescriptions* or *over the counter medications*? Please explain.

Are you currently taking any *vitamins, minerals, or food supplements*? Please explain.

SYMPTOMS:

In the last 90 days have you struggled with any of the following:

- | | |
|--|---|
| <input type="checkbox"/> Weight gain or inability to lose weight | <input type="checkbox"/> Waking tired in the morning, regardless of how many hours you've slept |
| <input type="checkbox"/> Food cravings (i.e. sugar, salt, coffee, alcohol) | <input type="checkbox"/> Fatigue in the afternoon around 3PM |
| <input type="checkbox"/> Gas or bloating | <input type="checkbox"/> Heavy periods or irregular periods |
| <input type="checkbox"/> Reflux | <input type="checkbox"/> Hot flashes or night sweats |
| <input type="checkbox"/> Bowel movements (not daily, hard to pass, or not fully eliminating) | <input type="checkbox"/> Mood shifts for no reason |
| <input type="checkbox"/> Headaches or migraines | <input type="checkbox"/> Anxiety or depression |
| <input type="checkbox"/> Pain in the neck or back | <input type="checkbox"/> Acne, psoriasis or eczema |
| <input type="checkbox"/> Swollen joints | <input type="checkbox"/> Allergies to grass/ trees/ pollen/ mold/ chemicals/ perfumes **If yes, fill in box below |
| <input type="checkbox"/> Difficulty focusing or loss of attention | <input type="checkbox"/> Allergies to foods**If yes, fill in box below |
| <input type="checkbox"/> Trouble falling or staying asleep | |

Check any of the substances you believe may be causing your problems

| | | | | |
|--|--|--|--|---|
| <input type="checkbox"/> Shell Fish | <input type="checkbox"/> Dairy (milk, cheese, yogurt, etc) | <input type="checkbox"/> Coffee, Chocolate, Tea (caffeine) | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Stinging Insects |
| <input type="checkbox"/> Wine, Beer, Alcohol | <input type="checkbox"/> Nightshades (tomatoes, potatoes, peppers) | <input type="checkbox"/> Laundry Detergents, Softeners | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Chemicals _____ |
| <input type="checkbox"/> Fruits/ Berries | <input type="checkbox"/> Grains | <input type="checkbox"/> Fabrics, Upholstery, Plastics | <input type="checkbox"/> Metals | <input type="checkbox"/> Drugs _____ |
| <input type="checkbox"/> Nuts/ seeds | <input type="checkbox"/> Herbal Remedies | <input type="checkbox"/> Latex | <input type="checkbox"/> Environmental (pollen, grass, mold) | |
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Nutritional Supplements | <input type="checkbox"/> Perfumes, Candles, Oils | <input type="checkbox"/> Animal Dander, Feathers, Fur | |

NUTRITION GOALS:

List your top 3 chief complaints/ health concerns

1. _____
2. _____
3. _____

What is your goal and/ or desired outcome? _____

How long do you think it will take to reach your goal?: _____

DIETARY HISTORY:

Have you ever been on a special diet? Please specify. _____

What methods of weight management have you previously tried? _____

Does anyone in your household follow a special diet? Please specify. _____

| | | | | |
|---|-----------------------------|------------------------------|------------------------------|----------------------------------|
| How many times/ day do you eat? | __Less than 3 | __3 | __4-5 | __More than 5 |
| How many cups (8 ounces) of coffee do you drink/ day? | __0 | __1 | __2 | __3 or more |
| How many sodas (8 ounces) do you drink/ day? | __0 | __1 | __2 | __3 or more |
| How many glasses (8 ounces=1 cup) of water do you drink /day? | __8-16 ounces (1-2 cups) | __17-40 ounces (3-5 cups) | __40-63 ounces (5-7 cups) | __64 ounces or more (8+ cups) |
| How many glasses (8 ounces=1 cup) of milk do you drink /day? | __1 cup | __2 cups | __3 cups | __4 or more cups |

When you eat away from home, where do you eat most often? (Check all that apply)

Restaurant _____ Grocery Store _____ Brown Bag _____
 Fast Food _____ Cafeteria _____ Other _____

How often do you eat away from home? _____ # of household members _____ Who prepares the meals? _____ Who does the grocery shopping? _____ How often? _____

ACTIVITY:

Describe your exercise program, if applicable. What do you do? How often? _____

Physically, do you consider your work: Very Active _____ Moderately Active _____ Light _____ Sedentary _____

Do you have a medical or physical condition that affects your diet or your ability to exercise?

Informed Consent

Living Well, LLC, Amy Richardson, Certified Nutrition Therapist (CNT) and Megan Magee, Registered Dietetic Tech (DTR) are not medical doctors. I understand that Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) do not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent as so doing. The services of a Nutrition Professional cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not, to assist you in your care is your right and Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) assume no responsibility for your decision in this matter. I have informed Living Well of all my known physical conditions, medical conditions, and medications, and I will keep them informed of any changes.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) as I so choose. I hereby release Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) and participate in a professional relationship with them pursuant to the statements herein.

| | | |
|-----------------------|--------------------|------|
| Client's Name (print) | Client's Signature | Date |
|-----------------------|--------------------|------|

| | | | |
|---|----------------------------|--------------------|------|
| <u>If Minor</u> , Client's Representative (print) | Signature of Client's Rep. | Relation to Client | Date |
|---|----------------------------|--------------------|------|