

Nutrition Assessment

Name: _____ Date: _____

Gender: F M Date of Birth: _____ Age: _____

Ancestral Background: African European Native American Mediterranean
 Asian Ashkenazi Middle Eastern _____

Job Title: _____ Business: _____

Relationship Status: _____ Children: _____

Phone: (h) _____ (c) _____ Email: _____

Physician: _____ Referred by: _____

PRIMARY CONCERN(S): _____

Medical History:

Personal Medical History: (e.g. diabetes, depression, obesity, etc.) _____

Substance history: smoking current past # of years _____
 alcohol current past per week: 1-3 4-6 7-10 >10

Recreational drug use: current past type & frequency _____

Family History: _____

Troubling Symptoms: _____

Medications, Vitamins, Minerals, Herbs & Other Supplements: *Please include dose, frequency & start date*

Name	Dose/Frequency	Start Date
<i>Example: Twin Lab Daily One Cap without iron</i>	<i>1 cap / once daily</i>	<i>Jan 2008</i>

Physical Activity:

Limitations to exercise: _____

Exercise:	Type	Frequency	Duration	Enjoy?
Cardio / Aerobic				
Strength				
Stretch				
Leisure / Sport				
Comments: _____				

Weight History:

Height: _____	Weight: _____	Weight 6 months ago: _____	Weight 1 yr ago: _____	Usual weight range: _____
Highest adult weight: _____		Lowest: _____		Desired weight range? _____
Weight fluctuations (>10 lbs.) <input type="checkbox"/> Yes <input type="checkbox"/> No				
BMI _____	Waist circumference _____		Body fat % _____	
Comments: _____				

Lifestyle

Stress & Coping: Daily stressors: rate on a scale of 1-10: Health _____ Work _____ Family _____ Social _____ Finances _____ Other (name) _____ Stress/Coping Techniques: _____ Comments: _____
Sleep Habits: Average number of hours per night: <input type="checkbox"/> >10 <input type="checkbox"/> 8-9 <input type="checkbox"/> 6-8 <input type="checkbox"/> <6 Sleep concerns: <input type="checkbox"/> Insomnia <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Awakenings <input type="checkbox"/> Snoring <input type="checkbox"/> Awake un-refreshed Comments _____

Food & Nutrition History

Have you made any recent changes in your eating habits? No Yes Describe _____

How would you describe your current diet? Vegetarian Vegan Gluten-Restricted No Dairy
 Gluten/Casein Restricted Weight-Loss Program _____ Other _____
 Food Allergy / intolerances _____ Other _____

Do you avoid any foods? Yes No If yes, describe _____

Do you crave any foods? Yes No If yes, describe _____

Do you grocery shop? Yes No Cook? Yes No If no, who does the cooking? _____

Number of meals out per week: 0-1 1-3 3-5 >5 meals per week

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

- | | |
|--|---|
| <input type="checkbox"/> Love to eat | <input type="checkbox"/> Don't care to cook |
| <input type="checkbox"/> Eat because I have to | <input type="checkbox"/> Reliance on convenience items |
| <input type="checkbox"/> Fast eater | <input type="checkbox"/> Poor snack choices |
| <input type="checkbox"/> Eat too much | <input type="checkbox"/> Travel frequently |
| <input type="checkbox"/> Emotional eater | <input type="checkbox"/> Challenges in obtaining healthy foods |
| <input type="checkbox"/> Negative relationship to food | <input type="checkbox"/> Significant other or family members don't like healthy foods |
| <input type="checkbox"/> Erratic eating pattern | <input type="checkbox"/> Significant other or family members have special dietary needs or food preferences |
| <input type="checkbox"/> Late night eating | <input type="checkbox"/> Eat because I have to |
| <input type="checkbox"/> Eating in the middle of the night | <input type="checkbox"/> Confused about nutrition advice |
| <input type="checkbox"/> Time constraints | |
| <input type="checkbox"/> Do not plan meals or menus | |
| <input type="checkbox"/> Comments: _____ | |

ASSESSMENT:

RECOMMENDATIONS:

Referrals: _____

Follow Up Appointment: _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are taking after the first time, record your symptoms for the last 48 hours ONLY.

POINT SCALE

0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe

2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

DIGESTIVE TRACT

- Nausea or vomiting
- Diarrhea
- Constipation
- Bloating feeling
- Belching, or passing gas
- Heartburn
- Intestinal/Stomach pain

Total _____

EARS

- Itchy ears Total
- Earaches, ear infections
- Drainage from ear
- Ringing in ears, hearing loss

Total _____

EMOTIONS

- Mood swings
- Anxiety, fear or nervousness
- Anger, irritability, or aggressiveness
- Depression

Total _____

ENERGY/ACTIVITY

- Fatigue, sluggishness
- Apathy, lethargy
- Hyperactivity
- Restlessness

Total _____

EYES

- Watery or itchy eyes
- Swollen, reddened or sticky eyelids
- Bags or dark circles under eyes
- Blurred or tunnel vision (does not include near-or far-sightedness)

Total _____

HEAD

- Headaches
- Faintness
- Dizziness
- Insomnia

Total _____

HEART

- Irregular or skipped heartbeat
- Rapid or pounding heartbeat
- Chest pain

Total _____

JOINTS/MUSCLES

- Pain or aches in joints
- Arthritis
- Stiffness or limitation of movement
- Pain or aches in muscles
- Feeling of weakness or tiredness

Total _____

LUNGS

- Chest congestion
- Asthma, bronchitis
- Shortness of breath
- Difficult breathing

Total _____

MIND

- Poor memory
- Confusion, poor comprehension
- Poor concentration
- Poor physical coordination
- Diff.iculty in making decisions
- Stuttering or stammering
- Slurred speech
- Learning disabilities

Total _____

MOUTH/THROAT

- Chronic coughing
- Gagging, frequent need to clear throat
- Sore throat, hoarseness, loss of voice
- Swollen/discolored tongue, gum, lips
- Canker sores

Total _____

NOSE

- Stuffy nose
- Sinus problems
- Hay fever
- Sneezing attacks
- Excessive mucus formation

Total _____

SKIN

- Acne
- Hives, rashes, or dry skin
- Hair loss
- Flushing or hot flushes
- Excessive sweating

Total _____

WEIGHT

- Binge eating/drinking
- Craving certain foods
- Excessive weight
- Compulsive eating
- Water retention
- Underweight

Total _____

OTHER

- Frequent illness
- Frequent or urgent urination
- Genital itch or discharge

Total _____

GRAND TOTAL _____

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group scores and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

Food Frequency Questionnaire (FFQ)

Name:				Date:	
Food or Beverage	Daily	1- 2 x per week	1 - 2 x per month	Comments:	Nutritionist's Notes:
Fruit					
Dried fruit					
Fruit juice					
Vegetables, raw					
Vegetables, cooked					
Vegetable juice					
Vegetables, starchy: peas, corn, winter squash, sweet potato, etc.					
Grains: Whole wheat, rye, barley, oats, Kamut, spelt					
Gluten Free (GF) grains: Rice, millet, quinoa, amaranth, buckwheat, corn					
Grain products: Bread, rolls, bagels, etc					
GF products: Bread, rolls, bagels, etc.					
Cereals: Low sugar, high fiber					
Cereals: High sugar					
Pasta					
Pasta: GF types					
Beans, hummus, lentils					
Veggie burgers					
Soups					
Soy foods: miso, tofu, tempeh,					

Edamame, soy milk, etc.					
Eggs					
Egg whites					
Fish					
Shellfish					
Poultry					
Red meat					
Frozen or convenience meals					
Cheese					
Yogurt					
Milk, skim					
Milk, 2%					
Milk, whole					
Non-dairy milks: Almond, hemp, rice, soy					
Protein powders or Greens Drinks Type:					
Energy bars- Brand:					
Nuts or seeds					
Nut butters: Almond, Cashew, Peanut					
Avocado					
Olives					
Oils- Types:					
Butter					
Margarine/spreads Type:					
Salad dressings					
Mayonnaise					
Mustard					
Ketchup or Salsa					
Soy sauce					
Frozen deserts: ice cream, frozen yogurt, etc.					
Muffins, cakes, cookies, pastries, donuts, etc.					

Chips: potato, corn, etc.					
Chocolate					
Candy					
Alcohol- Type: wine, beer, spirits					
Coffee: regular or decaf					
Tea: black, green, white, ,decaf, herbal					
Sodas or fruit drinks					
Diet sodas					
Water					
Other beverages- Type:					
Sweeteners- Type:					
Artificial sweeteners Type:					
Salt					
Pepper					
Seasonings:					
Other Foods Frequently Consumed					