Nutritional Assessment Questionnaire 1.5

Name: _____

Birth Date: _____

Date: _____/____/_____

Gender: _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

PART I Read the following questions and circle the number that applies:

KEY: 0 = Do not consume or use 2 = Consume or use weekly
1 = Consume or use 2 to 3 times monthly 3 = Consume or use daily

DIET

58

1. **0 1 2 3** Alcohol
2. **0 1 2 3** Artificial sweeteners
3. **0 1 2 3** Candy, desserts, refined
4. **0 1 2 3** Sugar
5. **0 1 2 3** Carbonated beverages
6. **0 1 2 3** Chewing tobacco
7. **0 1 2 3** Cigarettes
7. **0 1 2 3** Cigars/pipes
8. **0 1 2 3** Caffeinated beverages
9. **0 1 2 3** Fast foods
10. **0 1 2 3** Fried foods
11. **0 1 2 3** Luncheon meats
12. **0 1 2 3** Margarine
13. **0 1 2 3** Milk products
14. **0 1 2 3** Radiation exposure (0=no, 1=yes)
15. **0 1 2 3** Refined flour/baked goods
16. **0 1 2 3** Vitamins and minerals
17. **0 1 2 3** Water, distilled
18. **0 1 2 3** Water, tap
19. **0 1 2 3** Water, well
20 **0 1 2 3** Diet often for weight control

LIFESTYLE

12

21. **0 1 2 3** Exercise per week **(0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)**
22. **0 1 2 3** Changed jobs **(0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)**
23. **0 1 2 3** Divorced **(0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)**
24. **0 1 2 3** Work over 60 hours/week **(0 = never, 1 = occasionally, 2 = usually, 3 = always)**

MEDICATIONS

Indicate any medications you're currently taking or have taken in the last month **(0=no, 1=yes)**

54

25. **0 1** Antacids
26. **0 1** Antianxiety medications
27. **0 1** Anticonvulsants
28. **0 1** Antidepressants
29. **0 1** Antifungals
30. **0 1** Aspirin/Ibuprofen
31. **0 1** Asthma inhalers
32. **0 1** Beta blockers
33. **0 1** Birth control pills/implant contraceptives
34. **0 1** Chemotherapy
35. **0 1** Cholesterol lowering medications
36. **0 1** Cortisone/steroids
37. **0 1** Diabetic medications/insulin
39. **0 1** Diuretics
40. **0 1** Estrogen or progesterone (pharmaceutical, Antibiotics prescription)
41. **0 1** Estrogen or progesterone (natural)
42. **0 1** Heart medications
43. **0 1** High blood pressure medications
44 **0 1** Laxatives
45. **0 1** Recreational drugs
46. **0 1** Relaxants/Sleeping pills
47. **0 1** Testosterone (natural or prescription)
48. **0 1** Thyroid medication
49. **0 1** Acetaminophen (Tylenol)
50. **0 1** Ulcer medications
51. **0 1** Sildenafal citrate (Viagra)

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System

55

52. **0 1 2 3** Belching or gas within one hour after eating
53. **0 1 2 3** Heartburn or acid reflux
54. **0 1 2 3** Bloating within one hour after eating
55. **0 1** Vegan diet (no dairy, meat, fish or eggs) **(0=no, 1=yes)**
56. **0 1 2 3** Bad breath (halitosis)
57. **0 1 2 3** Loss of taste for meat
58. **0 1 2 3** Sweat has a strong odor
59. **0 1 2 3** Stomach upset by taking vitamins
60. **0 1 2 3** Sense of excess fullness after meals
61. **0 1 2 3** Feel like skipping breakfast
62. **0 1 2 3** Feel better if you don't eat
63. **0 1 2 3** Sleepy after meals
64. **0 1 2 3** Fingernails chip, peel or break easily
65. **0 1 2 3** Anemia unresponsive to iron
66. **0 1 2 3** Stomach pains or cramps
67. **0 1 2 3** Diarrhea, chronic
68. **0 1 2 3** Diarrhea shortly after meals
69. **0 1 2 3** Black or tarry colored stools
70. **0 1 2 3** Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 2 – Liver and Gallbladder

68

71. **0 1 2 3** Pain between shoulder blades
72. **0 1 2 3** Stomach upset by greasy foods
73. **0 1 2 3** Greasy or shiny stools
74. **0 1 2 3** Nausea
75. **0 1 2 3** Sea, car, airplane or motion sickness
76. **0 1** History of morning sickness **(0=no, 1=yes)**
77. **0 1 2 3** Light or clay colored stools
78. **0 1 2 3** Dry skin, itchy feet or skin peels on feet
79. **0 1 2 3** Headache over eyes
80. **0 1 2 3** Gallbladder attacks **(0=never, 1=years ago, 2=within last year, 3=within past 3 months)**
81. **0 1** Gallbladder removed **(0=no, 1=yes)**
82. **0 1 2 3** Bitter taste in mouth, especially after meals
83. **0 1** Become sick if you were to drink wine **(0=no,1=yes)**
84. **0 1** Easily intoxicated if you were to drink wine **(0=no, 1=yes)**
85. **0 1** Easily hung over if you were to drink wine **(0=no, 1=yes)**
86. **0 1 2 3** Alcohol per week **(0=<3, 1=<7, 2 =<14, 3=>14)**
87. **0 1** Recovering alcoholic **(0=no, 1=yes)**
88. **0 1** History of drug or alcohol abuse **(0=no, 1=yes)**
89. **0 1** History of hepatitis **(0=no, 1=yes)**
90. **0 1** Long term use of prescription/recreational drugs **(0=no, 1=yes)**
91. **0 1 2 3** Sensitive to chemicals (perfume, cleaning agents, etc.)
92. **0 1 2 3** Sensitive to tobacco smoke
93. **0 1 2 3** Exposure to diesel fumes
94. **0 1 2 3** Pain under right side of rib cage
95. **0 1 2 3** Hemorrhoids or varicose veins
96. **0 1 2 3** Nutrasweet (aspartame) consumption
97. **0 1 2 3** Sensitive to Nutrasweet (aspartame)
98. **0 1 2 3** Chronic fatigue or Fibromyalgia

Section 3 – Small Intestine

47

99. **0 1 2 3** Food allergies
100. **0 1 2 3** Abdominal bloating 1 to 2 hours after eating
101. **0 1** Specific foods make you tired or bloated **(0=no, 1=yes)**
102. **0 1 2 3** Pulse speeds after eating
103. **0 1 2 3** Airborne allergies
104. **0 1 2 3** Experience hives
105. **0 1 2 3** Sinus congestion, "stuffy head"
106. **0 1 2 3** Crave bread or noodles
107. **0 1 2 3** Alternating constipation and diarrhea
108. **0 1 2 3** Crohn's disease **(0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)**
109. **0 1 2 3** Wheat or grain sensitivity
110. **0 1 2 3** Dairy sensitivity
111. **0 1** Are there foods you could not give up **(0=no, 1=yes)**
112. **0 1 2 3** Asthma, sinus infections, stuffy nose
113. **0 1 2 3** Bizarre vivid dreams, nightmares
114. **0 1 2 3** Use over-the-counter pain medications
115. **0 1 2 3** Feel spacey or unreal

Section 4 – Large Intestine

58

116. **0 1 2 3** Anus itches
117. **0 1 2 3** Coated tongue
118. **0 1 2 3** Feel worse in moldy or musty place
119. **0 1 2 3** Taken antibiotic for a total accumulated time of **(0=never, 1= <1 month, 2= <3 months, 3= >3 months)**
120. **0 1 2 3** Fungus or yeast infections
121. **0 1 2 3** Ring worm, "jock itch", "athletes foot", nail fungus
122. **0 1 2 3** Yeast symptoms increase with sugar, starch or alcohol
123. **0 1 2 3** Stools hard or difficult to pass
124. **0 1 2 3** History of parasites (0=no, 1=yes)
125. **0 1 2 3** Less than one bowel movement per day
126. **0 1 2 3** Stools have corners or edges, are flat or ribbon shaped
127. **0 1 2 3** Stools are not well formed (loose)
128. **0 1 2 3** Irritable bowel or mucus colitis
129. **0 1 2 3** Blood in stool
130. **0 1 2 3** Mucus in stool
131. **0 1 2 3** Excessive foul smelling lower bowel gas
132. **0 1 2 3** Bad breath or strong body odors
133. **0 1 2 3** Painful to press along outer sides of thighs (Iliotibial Band)
134. **0 1 2 3** Cramping in lower abdominal region
135. **0 1 2 3** Dark circles under eyes

Section 5 – Mineral Needs

75

136. **0 1** History of carpal tunnel syndrome **(0=no, 1=yes)**
137. **0 1** History of lower right abdominal pains or ileocecal valve problems **(0=no, 1=yes)**
138. **0 1** History of stress fracture **(0=no, 1=yes)**
139. **0 1 2 3** Bone loss (reduced density on bone scan)
140. **0 1** Are you shorter than you used to be? **(0=no, 1=yes)**
141. **0 1 2 3** Calf, foot or toe cramps at rest
142. **0 1 2 3** Cold sores, fever blisters or herpes lesions
143. **0 1 2 3** Frequent fevers
144. **0 1 2 3** Frequent skin rashes and/or hives
145. **0 1** Herniated disc **(0=no, 1=yes)**
146. **0 1 2 3** Excessively flexible joints, "double jointed"
147. **0 1 2 3** Joints pop or click
148. **0 1 2 3** Pain or swelling in joints
149. **0 1 2 3** Bursitis or tendonitis
150. **0 1** History of bone spurs **(0=no, 1=yes)**
151. **0 1 2 3** Morning stiffness
152. **0 1 2 3** Nausea with vomiting
153. **0 1 2 3** Crave chocolate
154. **0 1 2 3** Feet have a strong odor
155. **0 1 2 3** History of anemia
156. **0 1 2 3** Whites of eyes (sclera) blue tinted
157. **0 1 2 3** Hoarseness
158. **0 1 2 3** Difficulty swallowing
159. **0 1 2 3** Lump in throat
160. **0 1 2 3** Dry mouth, eyes and/or nose
161. **0 1 2 3** Gag easily
162. **0 1 2 3** White spots on fingernails
163. **0 1 2 3** Cuts heal slowly and/or scar easily
164. **0 1 2 3** Decreased sense of taste or smell

BRAINWORKS FOR LIFE

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 6 – Essential Fatty Acids

22

165. **0 1** Experience pain relief with aspirin **(0=no, 1=yes)**
166. **0 1 2 3** Crave fatty or greasy foods
167. **0 1 2 3** Low- or reduced-fat diet **(0=never, 1=years ago, 2=within past year, 3=currently)**
168. **0 1 2 3** Tension headaches at base of skull
169. **0 1 2 3** Headaches when out in the hot sun
170. **0 1 2 3** Sunburn easily or suffer sun poisoning
171. **0 1 2 3** Muscles easily fatigued
172. **0 1 2 3** Dry flaky skin or dandruff

Section 7 – Sugar Handling

39

173. **0 1 2 3** Awaken a few hours after falling asleep, hard to get back to sleep
174. **0 1 2 3** Crave sweets
175. **0 1 2 3** Binge or uncontrolled eating
176. **0 1 2 3** Excessive appetite
177. **0 1 2 3** Crave coffee or sugar in the afternoon
178. **0 1 2 3** Sleepy in afternoon
179. **0 1 2 3** Fatigue that is relieved by eating
180. **0 1 2 3** Headache if meals are skipped or delayed
181. **0 1 2 3** Irritable before meals
182. **0 1 2 3** Shaky if meals delayed
183. **0 1 2 3** Family members with diabetes **(0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)**
184. **0 1 2 3** Frequent thirst
185. **0 1 2 3** Frequent urination

Section 8 – Vitamin Need

81

186. **0 1 2 3** Muscles become easily fatigued
187. **0 1 2 3** Feel exhausted or sore after moderate exercise
188. **0 1 2 3** Vulnerable to insect bites
189. **0 1 2 3** Loss of muscle tone, heaviness in arms/legs
190. **0 1 2 3** Enlarged heart or congestive heart failure
191. **0 1** Pulse below 65 per minute **(0=no, 1=yes)**
192. **0 1 2 3** Ringing in the ears (Tinnitus)
193. **0 1 2 3** Numbness, tingling or itching in hands and feet
194. **0 1 2 3** Depressed
195. **0 1 2 3** Fear of impending doom
196. **0 1 2 3** Worrier, apprehensive, anxious
197. **0 1 2 3** Nervous or agitated
198. **0 1 2 3** Feelings of insecurity
199. **0 1 2 3** Heart races
200. **0 1 2 3** Can hear heart beat on pillow at night
201. **0 1 2 3** Whole body or limb jerk as falling asleep
202. **0 1 2 3** Night sweats
203. **0 1 2 3** Restless leg syndrome
204. **0 1 2 3** Cracks at corner of mouth (Cheilosis)
205. **0 1 2 3** Fragile skin, easily chaffed, as in shaving
206. **0 1 2 3** Polyps or warts
207. **0 1 2 3** MSG sensitivity
208. **0 1 2 3** Wake up without remembering dreams
209. **0 1 2 3** Small bumps on back of arms
210. **0 1 2 3** Strong light at night irritates eyes
211. **0 1 2 3** Nose bleeds and/or tend to bruise easily
212. **0 1 2 3** Bleeding gums especially when brushing teeth

Section 9 – Adrenal

78

213. **0 1 2 3** Tend to be a "night person"
214. **0 1 2 3** Difficulty falling asleep
215. **0 1 2 3** Slow starter in the morning
216. **0 1 2 3** Tend to be keyed up, trouble calming down
217. **0 1 2 3** Blood pressure above 120/80
218. **0 1 2 3** Headache after exercising
219. **0 1 2 3** Feeling wired or jittery after drinking coffee
220. **0 1 2 3** Clench or grind teeth
221. **0 1 2 3** Calm on the outside, troubled on the inside
222. **0 1 2 3** Chronic low back pain, worse with fatigue
223. **0 1 2 3** Become dizzy when standing up suddenly
224. **0 1 2 3** Difficulty maintaining manipulative correction
225. **0 1 2 3** Pain after manipulative correction
226. **0 1 2 3** Arthritic tendencies
227. **0 1 2 3** Crave salty foods
228. **0 1 2 3** Salt foods before tasting
229. **0 1 2 3** Perspire easily
230. **0 1 2 3** Chronic fatigue, or get drowsy often
231. **0 1 2 3** Afternoon yawning
232. **0 1 2 3** Afternoon headache
233. **0 1 2 3** Asthma, wheezing or difficulty breathing
234. **0 1 2 3** Pain on the medial or inner side of the knee
235. **0 1 2 3** Tendency to sprain ankles or "shin splints"
236. **0 1 2 3** Tendency to need sunglasses
237. **0 1 2 3** Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

Section 10 – Pituitary

29

239. **0 1** Height over 6' 6" **(0=no, 1=yes)**
240. **0 1** Early sexual development **(before age 10) (0=no, 1=yes)**
241. **0 1 2 3** Increased libido
242. **0 1 2 3** Splitting type headache
243. **0 1 2 3** Memory failing
244. **0 1** Tolerate sugar, feel fine when eating sugar **(0=no, 1=yes)**
245. **0 1** Height under 4' 10" **(0=no, 1=yes)**
246. **0 1 2 3** Decreased libido
247. **0 1 2 3** Excessive thirst
248. **0 1 2 3** Weight gain around hips or waist
249. **0 1 2 3** Menstrual disorders
250. **0 1** Delayed sexual development (after age 13) **(0=no, 1=yes)**
251. **0 1 2 3** Tendency to ulcers or colitis

BRAINWORKS FOR LIFE

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 11 – Thyroid

48

252. **0 1 2 3** Sensitive/allergic to iodine
253. **0 1 2 3** Difficulty gaining weight, even with large appetite
254. **0 1 2 3** Nervous, emotional, can't work under pressure
255. **0 1 2 3** Inward trembling
256. **0 1 2 3** Flush easily
257. **0 1 2 3** Fast pulse at rest
258. **0 1 2 3** Intolerance to high temperatures
259. **0 1 2 3** Difficulty losing weight
260. **0 1 2 3** Mentally sluggish, reduced initiative
261. **0 1 2 3** Easily fatigued, sleepy during the day
262. **0 1 2 3** Sensitive to cold, poor circulation (cold hands and feet)
263. **0 1 2 3** Constipation, chronic
264. **0 1 2 3** Excessive hair loss and/or coarse hair
265. **0 1 2 3** Morning headaches, wear off during the day
266. **0 1 2 3** Loss of lateral 1/3 of eyebrow
267. **0 1 2 3** Seasonal sadness

Section 12 – Men Only

27

268. **0 1 2 3** Prostate problems
269. **0 1 2 3** Difficulty with urination, dribbling
270. **0 1 2 3** Difficult to start and stop urine stream
271. **0 1 2 3** Pain or burning with urination
272. **0 1 2 3** Waking to urinate at night
273. **0 1 2 3** Interruption of stream during urination
274. **0 1 2 3** Pain on inside of legs or heels
275. **0 1 2 3** Feeling of incomplete bowel evacuation
276. **0 1 2 3** Decreased sexual function

Section 13 – Women Only

60

277. **0 1 2 3** Depression during periods
278. **0 1 2 3** Mood swings associated with periods (PMS)
279. **0 1 2 3** Crave chocolate around periods
280. **0 1 2 3** Breast tenderness associated with cycle
281. **0 1 2 3** Excessive menstrual flow
282. **0 1 2 3** Scanty blood flow during periods
283. **0 1 2 3** Occasional skipped periods
284. **0 1 2 3** Variations in menstrual cycles
285. **0 1 2 3** Endometriosis
286. **0 1 2 3** Uterine fibroids
287. **0 1 2 3** Breast fibroids, benign masses
288. **0 1 2 3** Painful intercourse (dysparenia)
289. **0 1 2 3** Vaginal discharge
290. **0 1 2 3** Vaginal dryness
291. **0 1 2 3** Vaginal itchiness
292. **0 1 2 3** Gain weight around hips, thighs and buttocks
293. **0 1 2 3** Excess facial or body hair
294. **0 1 2 3** Hot flashes
295. **0 1 2 3** Night sweats (in menopausal females)
296. **0 1 2 3** Thinning skin

Section 14 – Cardiovascular

30

297. **0 1 2 3** Aware of heavy and/or irregular breathing
298. **0 1 2 3** Discomfort at high altitudes
299. **0 1 2 3** "Air hunger" or sigh frequently
300. **0 1 2 3** Compelled to open windows in a closed room
301. **0 1 2 3** Shortness of breath with moderate exertion
302. **0 1 2 3** Ankles swell, especially at end of day
303. **0 1 2 3** Cough at night
304. **0 1 2 3** Blush or face turns red for no reason
305. **0 1 2 3** Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
306. **0 1 2 3** Muscle cramps with exertion

Section 15 – Kidney and Bladder

13

307. **0 1 2 3** Pain in mid-back region
308. **0 1 2 3** Puffy around the eyes, dark circles under eyes
309. **0 1** History of kidney stones **(0=no, 1=yes)**
310. **0 1 2 3** Cloudy, bloody or darkened urine
311. **0 1 2 3** Urine has a strong odor

Section 16 – Immune system

30

312. **0 1 2 3** Runny or drippy nose
313. **0 1 2 3** Catch colds at the beginning of winter
314. **0 1 2 3** Mucus producing cough
315. **0 1 2 3** Frequent colds or flu **(0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)**
316. **0 1 2 3** Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) **(0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)**
317. **0 1 2 3** Never get sick **(0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)**
318. **0 1 2 3** Acne (adult)
319. **0 1 2 3** Itchy skin (Dermatitis)
320. **0 1 2 3** Cysts, boils, rashes
321. **0 1 2 3** History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition **(0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)**

BRAINWORKS FOR LIFE

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)