Nutrition Questionnaire

Please complete the following questionnaire before you schedule your next appointment. Take your time and answer all questions completely and openly. There are several pages at the end of the document that contain multi-day tests or histories. Please skip ahead to those pages and review the Axillary Temperature Test, and the 7-Day Diet History. Allow sufficient time for those to be completed prior to your next appointment. Please bring any and all blood work you have from the past two years.

Sincerely,
Mary Malott D.C., DACBN

Index

General Information

Name:	Birthdate:
Address:	Soc. Sec.#
City:	Emergency Contact:
State: Zip:	Relationship:
Phone: ( )	Phone: ( )
Work : ( )	Marital Status: S M D W

Your Health Care Providers

Your Family Physician	Name:	Phone: ( )
Your Family Dentist	Name:	Phone: ( )
Your Family Chiropractor	Name:	Phone: ( )
Other?	Name:	Phone: ( )
Other?	Name:	Phone: ( )

Please complete the following pages as directed. Keep in mind that the more honest about your eating, exercise, and health habits you are, the better the evaluation of your nutrition will be.

Mary Malott D.C., DACBN

Health Questionnaire 1.0

What is the main reason you are seeking nutrition counseling? (what, when and why).

Have you tried anything in the past for this?

Is the problem getting better or worse, or the same?

Are there other health concerns? (List most severe to least severe).

Drugs and Supplements being taken

Prescription medication	Dose	Times per day

Supplement	Dose	Times per day

Surgical History

List any surgeries or major injuries that you have had and when.

What Surgery/Injury?	When?

Familial History

List any family health/medical problems:

Put an **N** in the box if you have the condition now, or a **P** if the condition was in the past.

	Alcoholism	Allergies	Alzheimers	Arthritis	Asthma	Atherosclerosis	Cancer	Diabetes	Epilepsy	Glaucoma	Headaches	High Blood pres.	Kidney Disease	Obesity	Osteoperosis	Sinus Problems	Stroke	Thyroid Disease	Tuberculosis	Gastric ulsers
You																				
Spouse																				
Mother																				
Father																				
Children																				
Mat. G.Parents																				
Pat G. Parents																				
Sisters																				
Brothers																				

Familial History (continued)

Answer the following to the best of your abilities.

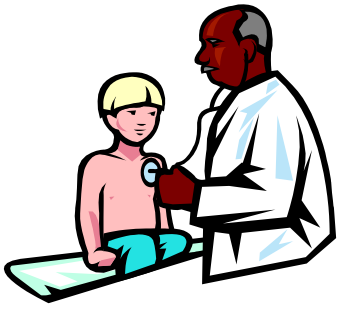
	Yes	No
My mother was healthy during her pregnancy with me?		
My Birth was easy (versus difficult or prolonged)?		
My birth was Natural, under Anesthesia, or C-Section	N	A C
Were you breast fed for the first 6 months?		
I was a colicky as a baby?		
Have you ever fainted or had a seizure?		
Have you traveled or lived in a foreign country?		

Where: _____

_____

I have had the following diseases

	Yes	No
Measles……		
Mumps……		
Rubella……		
Chicken Pox…		
Scarlet Fever...		
Hepatitis…….		
Herpes……		
Shingles…….		
Mononucleosis		
Cirrhosis……..		
Lymes Disease.		
Venereal Disease		
HIV/AIDS……		



Do You Have any Allergies ?

To What	Symptoms

Dietary History

List your 10 favorite foods

1)	6)
2)	7)
3)	8)
4)	9)
5)	10)

Give the amounts of each that you consume:

		Daily Oz ingested	**Daily?**	
Liquids		8 oz = 1 cup	Yes	No
	Water			
	Alcohol			
	Coffee/Tea			
	Soda			
	Juice			
	Milk			
Solids		% of **Weekly** total		
	Home Cooked			
	Resturant			
	Fast Food			
	Vending			
		100%		
	Fried			
	Baked			
	Broiled			
	Steamed			
	Microwave			
		100%		
	Fresh			
	Frozen			
	Canned			
	Prepackaged			
		100%		

My Appetite

Classify your appetite!

My appetite	Normal	☐	Excessive	☐	Poor	☐	Not so good	☐
I Crave	Sweets	☐	Salts	☐	Sour	☐	Water	☐
I Crave	Fast food	☐	Fried food	☐	Fruit	☐	Coffee	☐
I have trouble	Chewing	☐	Swallowing	☐	Tasting	☐	Smelling	☐

I drink mostly water from

Tap (city) ☐ Spring ☐ Well ☐ Bottled ☐ Filtered ☐

Foods that disagree with you

Raw Veges	☐	Greasy food	☐	Cabbage	☐	Nuts	☐
Milk / Dairy	☐	Beans	☐	Fried food	☐	Breads	☐
Spicy Food	☐	Fats	☐	Onions	☐	Red Meat	☐
Raw Fruit	☐	Eggs	☐	Sugar	☐	Fish	☐

Other : _____

_____

Diets I have tried

Check all that apply

Low Cholesterol	☐	Diabetic	☐	Ulcer Treating	☐	All Energy	☐
Low Fat	☐	Renal/ Kidney	☐	Diverticulits	☐	Slim Fast	☐
Low Salt	☐	High Fiber	☐	Complex Carbo's	☐	Body For Life	☐
Low Purine	☐	High Protein (Adkins)	☐	Calorie Restriction	☐	Fish	☐

Other : _____

_____

_____

_____

Clinical Details

What is your height? _____ Feet/inches

Have you lost any height? _____ Feet/inches

What is your current weight? _____ lbs

What do you consider your ideal weight? _____ lbs

Have you lost or gained any weight in the last 3 months? + / - _____ lbs

Do you want loose or gain any weight ? + / - _____ lbs

Activity level

What is your average activity level? Mild ☐ Moderate ☐ Heavy ☐

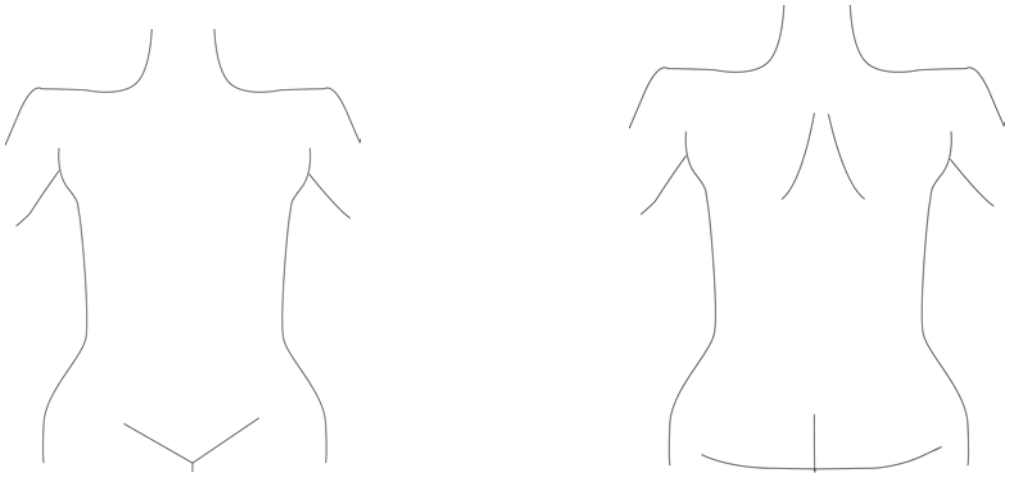
Do you exercise every day? Y / N How many times per week? _____

For how long do you exercise per session ? _____Mins Aerobic or Weights (circle)

Do you have a condition that prevents you from exercising? Y / N What? _____

Digestive function

Mark any areas of pain or indigestion. G = gas, P = pain, B = bloating, etc.



Front View Back view

Digestion (continued)

I get heartburn	Before eating		After eating		When I lie down		Upon rising	
I Get	Indigestion		Intestinal gas		Bloating		Belching	
How soon after eating	Immediately		1-2 hours		3-5 Hours		6+ hours	
These symptoms occur	Daily		Sometimes		Only after eating certain foods			
These symptoms are	Mild		Moderate		Severe			
I know I have	An ulcer		Hiatal hernia		Esophageal reflux			
Is there anything you can do to relieve the symptoms					Yes		No	

What? _____

Bowel Health

How often do you have a bowel movement? _____ times per day

Do you use laxatives? Y / N how many times per day? _____ Brand? _____

Do you experience pain with your bowel movement? Y / N

Do you have burning, itching, (other)_____ with your bowel movement? Y / N

Have you ever had worms or parasites? Y / N How was it treated?_____

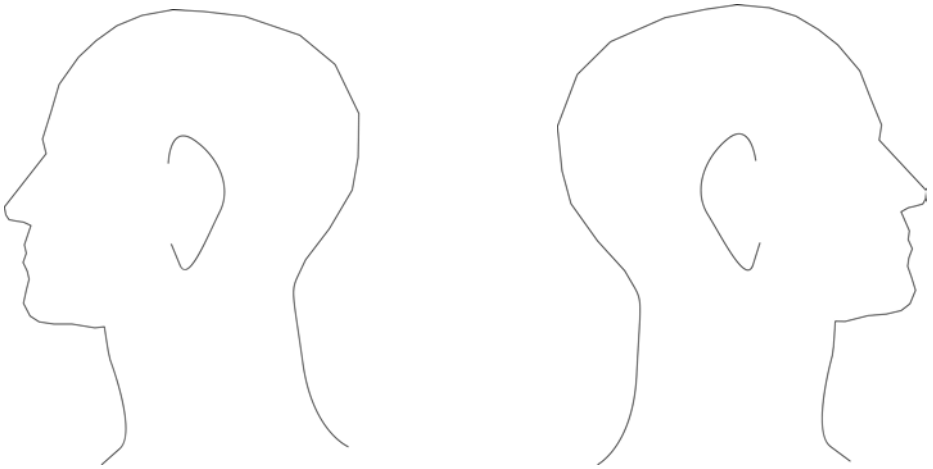
Stool

What best describes your stool qualities?

Stool Size		Stool Consistency		Stool Color	
Small & hard		Float on top		Med/dark brown	
Large & Hard		Float but underwater		Very Dark brown	
Thin, long, narrow		Sink to bottom		Yellow / tan / clay	
1” wide & 4 “ long		Soft but not loose		Greenish	
2” wide & 6 “ long		Loose - not diarrhea		Blood is visible	
Rabbit pellets		Diarrhea		Mucus is visible	
Difficult to pass		Varies with diet		Fluorescent orange	

Head, Mouth, and Throat

Mark any areas where your headaches arise or that are causing you pain.



Left Side Right Side

Headaches

I get headaches	Daily		Weekly		Rarely		Never
My headaches	Onset is with food or smell				Causes nausea or vomiting		
I frequently get	Is different for different causes				I get an "aura" with them		

Dental

My Teeth are	Good		Some fillings		Bad		Teeth missing	
I Wear Dentures	Upper		Lower		Partials		Crowns	
My Breath is	Good		Slight Odor		Off/On		Bad-offensive	

Tongue & Taste

My tongue is	Sore		Furrowed		Coated		Red Blotchy	
My sense of taste is	Good		Poor		Can only taste salty or spicy			
I frequently get	Cankers		Dry lips		Split lips		Oral sores	

Hair, Nails, & Skin

My skin is	Normal		Oily		Dry		Flaky	
	Acne		Psoriasis		Boils		Iitchy	
	Warts		Red Moles		Brn. moles		Wht. moles	
	I have / had skin cancer				Bumps on skin other than acne			

My Hair is	Course		Fine		Thinning		Crowns	
	Oily		Dry		Turned gray prematurely			
Male: Moustache/Beard	Heavy		Slight					
Females	Facial hair	Y/N	Stared at age?		Hair on abdomen or breasts			
My skin is	Normal		Oily		Dry		Flaky	

My Nails are	Dry		Cracked		Ingrown		fungus	
	Cracked or bleeding nails				On Hands		On Feet	

Muscles, Ligaments, Tendons, Vessels, and Blood

I have had pain in my	Neck		Mid Back		Low Back		Hips	
	Knees		Ankles		Feet		Toes	
	Shoulders		Elbows		Hands		Fingers	

I have had	Swollen Joints		Sore Joints		Joints that pop or crack		Leg cramps or restless leg	
	Jaw pops		Flat feet		Burning feet		Foot cramps	
	Tingling in feet or hands				Cramps are worse at night			
I am better in	Warm weather				Cold Weather			

List and medications that have helped with the above symptoms: _____

_____

_____

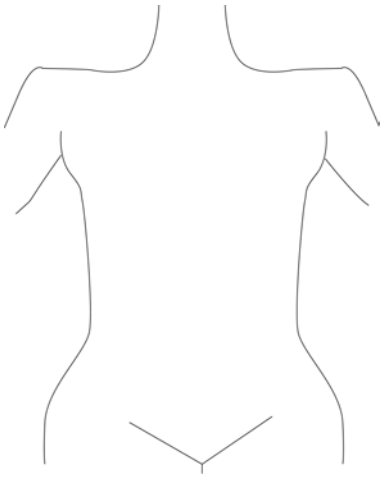
I have/ suffer from	Epilepsy		Parkinson's		Bell's Palsy		Fibromyalgia	
	Sciatica		M. S.		Nervous tick or twitching			

I have had spinal surgery? Y / N

Where?:_____When:_____

I have had	Heart attack		A Stroke		Angioplasty		Bypass surgery	
I	Chest pain		→ Mild		Moderate		Severe	
	It radiates		→To Arm		To Neck		To Back	
	Worse on Exertion				Better with Exertion			
	Better with Rest				No change with exercise			

Mark on the picture (**X**) any areas of chest pain that you have had. Mark any radiating pain (**R**). Mark any surgery sites (+++++) from chest, thoracic, or abdominal surgery



Chest Front View

My pulse/Heartbeat is	Too fast		Too slow		Skips beats		Weak	
I have	High Blood pressure		Last reading ____/____		Low Blood Pressure		Highest reading _____/_____	
I am on	Blood Pressure medicine		Diuretics e.g. lasix		Nitro-glycerine		Digoxin / digitonoin	

I have / had	Varicose veins		Spider veins		Hemor-rhoids		Vessel surgery	

Respiratory System

I have been told that I have	Lung disease		Emphysema		Collapsed lung		Lung cancer	
	I Smoke _____packs a day				Cigars/pipe		Chew Tobacco	
I have Nasal Congestion	Daily		Weekly		All the time		Rarely	
I have nasal discharge	Daily		Weekly		All the time		Rarely	
My discharge is	Clear		Yellow		Green		Bloody	
I have coughing	Daily		Weekly		All the time		Rarely	
My cough is	Dry		Productive		Wheezing		Snorting	
I have	Post nasal drip				Hoarseness of voice			

I have / had	Frequent colds		Flu more than 1x yr.		Pneumonia		Sinus infections
	Allergies		Asthma		Allergy shots		Steroid Oral or shots
	I have taken antibiotics more than 3 separate times in my life						
I routinely take these	Antihistamines				Decongestants		

I am exposed to	2nd hand smoke		Toxic chemical (e.g. labwork)	
I work with	Dusty/debris/		Paints/crafts	
I live	Near chemical plants		In a highly polluted airspace	

Nervous system / Emotions

I have been	Nervous		Anxious		Depressed		irritable
	fatigued		fearful		Confused		Weak
	Forgetful		Exhausted		Sensitive to noise		

I often	Avoid crowds		Sleep all day		Lose my appetite		Hear voices

I have these feelings	Morbid thoughts		Suspicion of others	
	Quick mood changes		Thoughts of suicide	

I dream	Never		Always		Too much		nightmares

Rate the quality of your sleep	Poor		Good		Excellent		Variable
I often wake feeling	Rested		Tired		Needing a nap		Disoriented

Metabolism

My metabolism is	High		Average		Low		Don't know
I often feel / am	Hot		Cold		Sweating		I don't sweat
	My hands and feet are often →				Hot		Cold

It seems that	I eat very little but still gain weight		I can eat all I want without gaining weight	

Male Specific Questions

My Prostate is	Normal		Enlarged		had cancer		Removed	

I have	Painful urination		Difficulty starting urine flow	
	Difficulty stopping flow		Dribbling of urine	
	Decreased stream size		Pain or pressure after starting	
	Burning discharge		I get up ____ times to urinate at night	

My urine color is	Pale Yellow		Bright yellow		Dark yellow		Reddish	
It looks	Clear		Cloudy		With mucus		Variable	
I also have	Hernias		Impotency		Pain In testicles or scrotum			
My libido is	High		Average		Low		absent	

Female Specific Questions

My menstrual period	Started at age _____				Date of last period ___/___/____			
My period is/was	Normal		Regular		irregular		Painful	
	Heavy		Light		Scant		With clots	
The color was	Pink		Red		Brown		Black	
I experience pain	First day only		Throughout		At the end		Mine are not painful	
I experience bloating	_____ days before my period				_____ days after my period ends			
I have PMS symptoms	Never		sometimes		Every time		What's PMS	

I have/had	__ children		Miscarried		No pregnancy		A hysterectomy	
My Uterus	Is in the normal position				Is tipped out of position			
My menstrual problems	Stated before my first child				After my first child			
I want	To have children (more)				I do not want any more children			

Birth control	Not needed		The pill		IUD		Diaphragm	

Menopause	Started at age _____				I had a hysterectomy at age ____				
Hormone replacement	Estrogen		Progestin		Oral		Patch		Wild Yam

I have had	Endometriosis		Cervical /vaginal cancer		Fibroids	

Women only section (continued)

Breast	Firm		Soft/saggy		Implants (19___)		Reduction	
Soreness	Before period		During period		After period			
I have had	Fibrocystic disease		Breast cancer		Persistent lactation			

Bladder infections	Never		Sometimes		Often		Yeast infections	
I have had to take / use	douches		antibiotics		antifungals		Oral antifungals	
I have had	Vaginal burning		Vaginal dryness		Painful intercourse			

I have	Painful urination		Difficulty starting urine flow	
	Difficulty stopping flow		Dribbling of urine	
	Decreased stream size		Pain or pressure after starting	
	Burning discharge		I get up ____ times to urinate at night	

My urine color is	Pale Yellow		Bright yellow		Dark yellow		Reddish	
It looks	Clear		Cloudy		With mucus		Variable	
My libido is	High		Average		Low		absent	

List any other health concerns not addressed in the packet so far:

_____

_____

_____

_____

_____

_____

_____

_____

The following pages contain 7 day tests / histories: read all instructions and start recording data at least 7 days before your next appointment so that the information is complete.

Axillary Temperature Test

There is sufficient evidence to indicate that one of the better means of detecting subclinical Hypothyroidism (low thyroid levels) is by measuring the body's ability to regulate temperature over a 6-day period. It is important that you follow the directions completely to ensure that the test is as variable free as possible. It is important that you take your temperature when you are at rest and when you are relaxed.

Instructions

1. Use an oral thermometer that has been shaken down and has sat on the nightstand overnight.
2. Place the thermometer in your armpit for ten minutes and record your temperature each morning, for at least six consecutive mornings. Do this before you get out of bed, before you have urinated, or have had any food or coffee (the hardest part).
3. For women, additional consideration is needed during ovulation or menstruation. For women who are still menstruating, you may begin recording on the 2nd or 3rd day of your cycle. Post menopausal women may start at any time.

We have included 10 spaces for you to try this out. When finished please circle indicate the six consecutive days that you feel were best representative of your true basal temperature (had the least error - e.g. days 3-9).

Date	Temp (F°)	Date	Temp (F°)
1)		6)	
2)		7)	
3)		8)	
4)		9)	
5)		10)	

My Best 6 consecutive dates are days _____ through _____.

Average =_____ F°

7-Day Diet History

List the food and beverages you consume over a 7-day period. Please indicate not only the food, but the approximate amount you consume (e.g. green beans –1 cup, Milk-8 oz).

	Breakfast	Lunch	Dinner	Snacks / Other
Day 1				
Day 2				
Day 3				
Day 4				
Day 5				
Day 6				
Day 7				