PATIENT NAME	DATE

Patient Questionnaire

Please list up to three main health/nutrition concerns.

What do you hope to achieve during this visit?

Please list any known food or environmental allergies.

Please list all medications (attach a separate sheet if needed)

Please list all nutrition and other supplements

Have you had prolonged use of acid-blocking drugs for heartburn or GERD? ☐Y ☐N

Have you had recent or frequent antibiotic use (> 3 times per year)? ☐Y ☐N

Oral health: Do you have (Please circle all that apply):

☐ Dentures ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

☐ Thrush ☐ Missing teeth ☐ Other oral health concerns

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Medical History: Please check all that apply

Gastrointestinal	Immune/Inflammatory	Respiratory
☐ Celiac Disease ☐ Crohn's Disease ☐ Gastric or Peptic Ulcers ☐ Heartburn/GERD/Reflux ☐ Irritable Bowel Syndrome ☐ Ulcerative Colitis ☐ Liver Disease/Fatty Liver ☐ Constipation ☐ Diarrhea ☐ Kidney Disease ☐ Small Intestinal Bacterial Overgrowth	☐ Chronic Fatigue Syndrome ☐ Epstein-Barr Virus ☐ Grave's Disease ☐ Gout ☐ Hashimoto's Thyroiditis ☐ Lupus ☐ Rheumatoid Arthritis ☐ Frequent Infections ☐ Other	☐ Asthma ☐ COPD ☐ Chronic Bronchitis ☐ Chronic Sinusitis ☐ Sleep Apnea ☐ Other Nervous System ☐ Neuropathy ☐ Gastroparesis ☐ Restless Legs
Musculoskeletal/Pain	**Cardiovascular**	**Cancer (Type and Time of Diagnosis)**
☐ Chronic Pain ☐ Fibromyalgia/Chronic Fatigue ☐ Migraine ☐ Osteoarthritis ☐ Osteoporosis or Osteopenia ☐ Other	☐ Atherosclerosis ☐ Elevated Cholesterol ☐ Heart Attack ☐ High Blood Pressure ☐ Stroke ☐ Other	
Skin	**Metabolic/Endocrine**	
☐ Acne ☐ Eczema ☐ Psoriasis ☐ Rosacea ☐ Skin Rash ☐ Other	☐ Diabetes Type 1 ☐ Diabetes Type 2 ☐ Adult-Onset Type 1 Diabetes(LADA) ☐ Pre-Diabetes ☐ Gestational Diabetes ☐ Hypoglycemia ☐ Hypothyroidism ☐ Hyperthyroidism ☐ Hashimoto's Thyroiditis ☐ PCOS	

Nutrition History:

Have you ever had a nutrition consultation? ☐Y If yes, when and where?_____ ☐N

Have you made and changes in your eating habits because of your health? ☐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:

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% ☐ 20-50% ☐ <25%

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

Where do you eat out most often?

_____

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

Do you crave any foods?

How much coffee, tea or other caffeine – containing beverages do you consume each day?

Energy Drinks _____ ounces Coffee _____ ounces Black/Green Tea _____ Other _____ ounces

How much plain water do you drink each day?_____ ounces

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
- ☐ Love to eat
- ☐ Love to cook
- ☐ Family members have different dietary needs
- ☐ Live or often eat alone
- ☐ Time constraints
- ☐ Drink Soda
- ☐ 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:

_____

_____

_____

Blood Sugar Log

Do you check your blood sugar at home? ☐Y ☐N How many times a day?_____

When do you check and what are your readings?

☐ Before breakfast	☐ Before lunch	☐ Before dinner	☐ After meals 1 hour / 2 hours	☐ Before bed	☐ 2 -3 AM

What is your A1C.?

_____

Do you have any questions regarding technique using your:

☐ Blood glucose monitor? ☐ Insulin injections?

Exercise:
Do you currently engage in a regular exercise routine? ☐Y ☐N
If yes, what activity do you do? # Days per week?

Note any problems that limit your physical activity.

Do you smoke? ☐Y ☐N	Do you chew tobacco? ☐Y ☐N	Do you drink alcohol? ☐Y ☐N	Drinks per day?	Secondhand smoke exposure? ☐Y ☐N

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 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

How would you rate the overall quality of your sleep? ☐ 1 Low ☐ 2 ☐ 3 ☐ 4 ☐ 5 High

What is your occupation?

Readiness Assessment:
What lifestyle changes do you think would improve your health the most?

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 on 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

Comments

PATIENT SIGNATURE	DATE
STAFF SIGNATURE	DATE

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