



Elisa Song, MD | Donna Ruiz, MD | Suruchi Chandra, MD | Christina Peretz, MD | Kandice Stellmon, NC

Nutrition Questionnaire

Thank you for taking the time to fill out this nutrition questionnaire. This questionnaire is an important part of your, or your child's, initial consultation. Accurate completion of this form will ensure more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will assist your Nutritional Consultant in formulating the most appropriate nutrition plan.

Personal Information	
Patient's Name: _____	Date of Birth: _____ Male Female
Height: _____	Weight: _____
Body Frame: _____	Blood type (if known): _____
Form Completed by (include relation to patient): _____	
Name/Address of Primary Care Physician: _____	
Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any): _____	
Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any): _____	
Name/Address of Additional Therapists/Specialists Working With You, or Your Child (if any): _____	

Please check appropriate box(es):

- African American Hispanic Mediterranean Asian
- Native American Caucasian Northern European Other _____



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Health Concerns and History

What are your main objectives for seeing a nutrition professional?

Describe onset and occurrence of health problems in detail:

How have you previously dealt with these concerns (doctors, self-care) and with what results?

Please briefly describe your, or your child's, health history (use additional sheet at the end of this document if necessary):

Have any other family members had similar problems? Yes No (If yes, describe):



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Medication/Supplement History			
Please list all current medications, vitamins, nutritional supplements, herbs, homeopathic remedies, etc. (use additional sheet at the end of this document if necessary):			
<u>Supplement/Medication</u>	<u>Dose</u>	<u>Frequency</u>	<u>Date Started</u>

Medication/Supplement History	
Please list all medications/supplements stopped secondary to not working or negative response. If there was a negative response, please describe. (use additional sheet at the end of this document if necessary):	
<u>Supplement/Medication</u>	<u>Reason Stopped</u>



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Dietary History
Do you, or your child, have any food allergies or food intolerances that you know of? Please list them, if known:
Describe any history of dieting or disordered eating (yo-yo dieting, bingeing, anorexia, bulimia, etc.):
Do you, or your child, have any food cravings or addictions (i.e. sugar, breads, ice cream, etc.) Please describe:
Are you, or your child, currently following any special diet? Please check off which one(s): <input type="checkbox"/> No restrictions <input type="checkbox"/> Gluten Free <input type="checkbox"/> Casein Free <input type="checkbox"/> Yeast Free <input type="checkbox"/> Feingold <input type="checkbox"/> Body Ecology Diet <input type="checkbox"/> Raw Diet <input type="checkbox"/> Ketogenic <input type="checkbox"/> Vegetarian <input type="checkbox"/> Specific Carbohydrate Diet <input type="checkbox"/> Other (please describe):

Digestive History
How often do you have a bowel movement?
What is your stool like (check all that apply)? <input type="checkbox"/> Well-formed <input type="checkbox"/> Mucousy <input type="checkbox"/> Loose, falls apart <input type="checkbox"/> Watery <input type="checkbox"/> Small, hard pieces <input type="checkbox"/> Greasy, floats <input type="checkbox"/> Bloody <input type="checkbox"/> Thin and long, ribbons <input type="checkbox"/> Foul-smelling <input type="checkbox"/> Painful <input type="checkbox"/> Lots of undigested food particles <input type="checkbox"/> Medium/dark brown <input type="checkbox"/> Yellow/light brown <input type="checkbox"/> Greenish <input type="checkbox"/> Very dark or black <input type="checkbox"/> Other (please describe):
Do you have heartburn or reflux? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please list any treatments):
Do you have frequent gas or belly bloating? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe):
Do you have any abdominal pain? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please describe how often and nature of pain):



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Stress

Please describe areas of stress in your, or your child's, life (family, work, relationships, school, etc.):

On a scale of 1-10, how would you rate your, or your child's, stress? (10 being the most stressed):

Sleep History

How many hours of sleep do you, or your child, get every day?

What time do you, or your child, typically fall asleep at night?

What time do you, or your child, typically wake up?

Do you, or your child, need an alarm clock to wake up in the morning? Yes No

Do you, or your child, feel refreshed upon waking up in the morning? Yes No

Describe the quality of your, or your child's, sleep?

Environmental Exposures

Are you, or your child, exposed to any of the following:

- | | | | |
|--|---|------------------------------------|---|
| <input type="checkbox"/> Tap water | <input type="checkbox"/> Air pollution | <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Food & Chemical residues |
| <input type="checkbox"/> Amalgam Fillings | <input type="checkbox"/> Perfumes/Fragrances | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Chemical Cleaning supplies |
| <input type="checkbox"/> Artificial Sweeteners (NutraSweet, Equal, etc.) | <input type="checkbox"/> OTC Medicines (Aspirin, Tylenol, etc.) | | |
| <input type="checkbox"/> Other (please describe): | | | |



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Other Concerns

Do you have any other concerns that you would like to mention? Please describe:

For Pediatric Clients Only

Please describe pregnancy and birth:

Was your child fed anything other than breast milk during his/her first 6 months of life? Yes No
If yes, which foods?

Did your child receive formula? Yes No
If yes, which type of formula (cow's milk, soy, etc.)?

Does your child have sensory issues surrounding food (i.e., will only eat foods of certain textures, colors, etc.)?
 Yes No If yes, please describe:

Would you consider your child a "picky eater"? Yes No If yes, please describe:



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Additional Space

Please use this area when additional space was needed elsewhere in the questionnaire.