

Nutritional Assessment Questionnaire 1.5

Name: _____

Date: ____/____/____

Birth 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

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

LIFESTYLE

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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):

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|--|---|
| 25. 0 1 Antacids | 39. 0 1 Diuretics |
| 26. 0 1 Antianxiety medications | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics | 41. 0 1 Estrogen or progesterone (natural) |
| 28. 0 1 Anticonvulsants | 42. 0 1 Heart medications |
| 29. 0 1 Antidepressants | 43. 0 1 High blood pressure medications |
| 30. 0 1 Antifungals | 44. 0 1 Laxatives |
| 31. 0 1 Aspirin/Ibuprofen | 45. 0 1 Recreational drugs |
| 32. 0 1 Asthma inhalers | 46. 0 1 Relaxants/Sleeping pills |
| 33. 0 1 Beta blockers | 47. 0 1 Testosterone (natural or prescription) |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication |
| 35. 0 1 Chemotherapy | 49. 0 1 Acetaminophen (Tylenol) |
| 36. 0 1 Cholesterol lowering medications | 50. 0 1 Ulcer medications |
| 37. 0 1 Cortisone/steroids | 51. 0 1 Sildenafil citrate (Viagra) |
| 38. 0 1 Diabetic medications/insulin | |

PART II (See key at bottom of page)

Section 1 – Upper Gastrointestinal System

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness 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 2=Moderate symptom, occurs occasionally (weekly)
 1=Yes, minor or mild symptom, rarely occurs (monthly) 3=Severe symptom, occurs frequently (daily)

Section 2 – Liver and Gallbladder

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- 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

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- 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=current 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

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- 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 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

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- 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

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

Section 6 – Essential Fatty Acids

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- 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=currenty)
- 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

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- 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

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- 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 2 3 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

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- 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

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- 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

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

Section 11 – Thyroid

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

Section 12 – Men Only

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

Section 13 – Women Only

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

Section 14 – Cardiovascular

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

Section 15 – Kidney and Bladder

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

Section 16 – Immune system

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|------|---------|---|------|---------|--|
| 312. | 0 1 2 3 | Runny or drippy nose | 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) |
| 313. | 0 1 2 3 | Catch colds at the beginning of winter | 318. | 0 1 2 3 | Acne (adult) |
| 314. | 0 1 2 3 | Mucus producing cough | 319. | 0 1 2 3 | Itchy skin (Dermatitis) |
| 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) | 320. | 0 1 2 3 | Cysts, boils, rashes |
| 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) | 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) |

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