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INTEGRATIVE NUTRITION BACKGROUND QUESTIONNAIRE

Note: All information is kept strictly confidential.

Name: ______________________________ Today's Date: ______________________________

Address: ______________________________ Date of Birth: ________________ Age: _____

______________________________ Sex: M F Marital Status: S M D W

Phone: (H) ______________________________ Number of Children: ____________________

Phone: (W) ______________________________ Referred by: ______________________________

Is it okay to call you at work? Y N

Occupation: ______________________________ Email Address: ______________________________

Primary Care Physician (PCP): ________________________ Phone: ____________________

PCP Address: ____

Goals for Nutritional Counseling / Reasons for coming in:

1. ____
2. ____
3. ____
4. ____

Current Medical Problems / Diagnoses:

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

List all medications you are currently taking and their dosages (List nutritional supplements in the next section)**:**

1. ______________________________ 5. ______________________________
2. ______________________________ 6. ______________________________
3. ______________________________ 7. ______________________________
4. ______________________________ 8. ______________________________

List the names and amounts of supplements you take on a regular basis (you can bring a list):

1. ______________________________ 5. ______________________________

2. ______________________________ 6. ______________________________

3. ______________________________ 7. ______________________________

4. ______________________________ 8. ______________________________

Weight Assessment: Height =__________ Weight =__________ (BMI =_________)

Allergies / Intolerances:

Medications – ____

____

Foods – ____

____

Symptoms – Check (✓) all symptoms you currently have or have had in the past year**:**

GENERAL

- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of sleep
- ☐ Loss of weight
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

- ☐ Arms
- ☐ Back
- ☐ Feet
- ☐ Hands
- ☐ Hips
- ☐ Legs
- ☐ Neck
- ☐ Shoulders

GENITO-URINARY

- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

GASTROINTESTINAL

- ☐ Appetite poor
- ☐ Bloating
- ☐ Bowel changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR

- ☐ Chest pain
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE, THROAT

- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Earache
- ☐ Ear discharge
- ☐ Hay fever
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Persistent cough
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Vision – Flashes
- ☐ Vision – Halos

SKIN

- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only

- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period ______________

Date of last Pap Smear ________________

Have you had a mammogram? ______________

Are you pregnant? ____________

Number of children ____________

Family History:

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:		
						Disease	Relationship to you
Father						Arthritis, Gout	
Mother						Asthma, Hay Fever	
Brothers						Cancer	
						Chemical Dependence	
						Diabetes	
						Heart Disease, Stroke	
Sisters						High Blood Pressure	
						Kidney Disease	
						Tuberculosis	
						Other	

Hospitalizations / Serious Illnesses or Injuries:

Year	Reason for Hospitalization or Nature of Illness or Injury

Pregnancy: List number, complications if any, etc.

____

____

____

Dietary Information

Typical Day's Diet	Typical Snacks
Breakfast: ______________________	______________________
______________________	______________________
______________________	______________________
Lunch: ______________________	______________________
______________________	______________________
______________________	______________________
Dinner: ______________________	______________________
______________________	______________________
______________________	______________________

Number of cups of coffee or caffeinated drinks per day: _____

Glasses of water per day: _____

Do you cook? _____

If yes, do you make enough food at dinner to have leftovers for another meal? _____

What percentage of your dinner meals are eaten at home? _____

Do you eat at fast food restaurants (e.g. Burger King, McDonalds, etc.)? _____

If yes, average number of times per week _____ *or* < 1 time per week

Do you get sugar cravings (circle one answer)? Yes No Sometimes

Do you get carbohydrate cravings? Yes No Sometimes

Are you an emotional or comfort eater? Yes No Sometimes

Do you binge eat or eat without being able to control your eating? Yes No Sometimes

Have you been on specific diets? _____ If yes, please list: ______________________

____

Lifestyle and General Health Questions:

1. How is your energy? ¨______________________________________
2. How many hours of sleep do you get? ______ Any difficulty falling asleep? ________ staying asleep? __________ Early morning awakening? ______________________
3. Time of day you have the most energy? ______________________
4. Do you get tired easily? ______________________
5. Do you exercise? _____ If yes, please specify type and amount of exercise: ________ ____
6. Do you drink alcohol? _____ If yes, how many per week: _____ *or* < 1 per week
7. Do you smoke? _____ If yes, cigarettes per day: _____ *or* packs per day: _____

8. How many times have you taken antibiotics?

	Less than 5 times	Greater than 5 times
As an infant or child		
As a teenager		
As an adult		

9. Stress level overall – please circle one: Low Moderate High Very High

10. Stress level at work – please circle one: Low Moderate High Very High

11. Stress level at home – please circle one: Low Moderate High Very High

12. Stress level comments or descriptions: ____

____

13. Do you practice stress reduction techniques? _____ If yes, please specify type and amount of practice: ____

14. How much supportiveness do you feel you have from family and/or friends:

Poor Fair Good Very Good

15. What do you do for fun? ____

____

16. What hobbies do you have? ____

____

17. Are you active in religious or spiritual organizations? ___________________________

18. Do you have your own religious or spiritual practices at home or with family and/or friends? ____

19. With whom do you live? ____

____

20. Do you have any pets? Please list. ____

____

21. Do you spend significant time outdoors or in wooded areas? _____________________

____

22. Have you lived abroad or done significant foreign travel? ________________________

____

23. How do you feel emotionally? ____

____

24. How would you describe your childhood and adolescence?

Very Happy   Happy   Okay   Unhappy

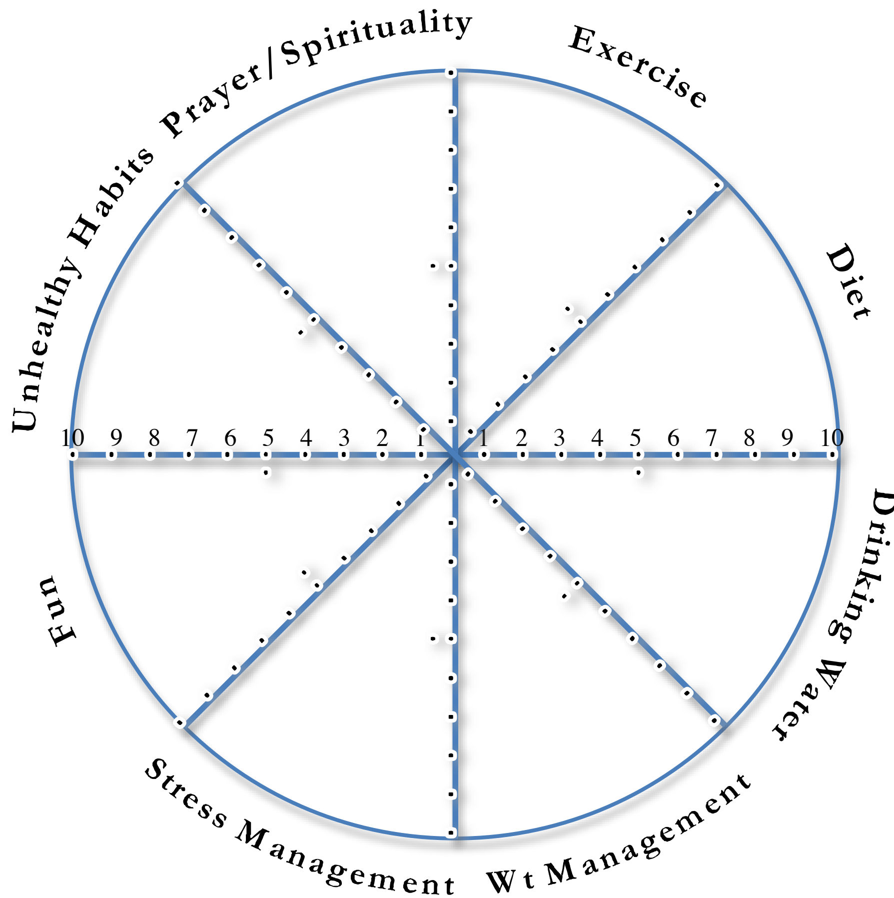
Optional Comments: ____

____

25. Do you feel that based on your beliefs and goals that your life is where you would like it to be or moving in the right direction? ______________________________________

____

26. HEALTH WHEEL: How satisfied are you with your effort in each area? Draw a line across each section at the point that describes your satisfaction level.



Any Additional Comments or Information: ____

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