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Live Well Love Food

Health Questionnaire

Contact Information

Name: ____

Home Phone: (   ) ____-______

Cell Phone: (   ) ____-______

Current Address: _______________________________

____

Email: ____

Personal Information

Sex: ☐ M ☐ F

Date of Birth: _____________ Age: _____________

Height: __________________

Current Weight: _________________

Reason for your visit: ____________________________________

Relationship Status:
☐Single ☐ Married ☐Divorced ☐Separated

Ethnicity: __________________________________

Number of Children: ________

Occupation: _____________________________________

Sleep Patterns

When is your usual bedtime?____________________________ Rising time?______________________________

Do you use an alarm clock to wake up? ☐ Yes ☐ No

Do you wake up in the middle of the night or early morning? ____

Stress Level

On a scale of 1 to 10 (10 being the highest), how stressed are you? __________________________________

List your stressors: ____

____

Lifestyle Habits

How would you describe your general health? ____

____

What is your chief complaint? ____

Symptoms?____

What aggravates your symptoms (diet, environment)?____

____

Smoke tobacco? ☐ Yes ☐ No How much?

Drink alcohol? ☐ Yes ☐ No How much?

Recreational drug use? ☐ Yes ☐ No What kind and how often?

Blood Pressure – ☐ Low ☐ Moderate ☐ High

When was the last time you were prescribed antibiotics? ______________________________

What were they prescribed for? ______________________________

Do you engage in any physical activity?

What type?______________________________

Duration (x per week)______________________________

List other hobbies or recreational activities: ______________________________

Medication/Supplements (Continued)

Name	Dosage	How Often	Reason

Eating Habits/Digestive Health

How much water do you drink daily? __________oz.

Do you drink coffee? ☐Yes ☐No Cups per day: _____

Do you drink soda? ☐Yes ☐No Cups per day: _____

List some of your favorite foods: ______________________________

____

____

List foods that you crave:______________________________

____

List foods that you craved as a child: ______________________________

____

List foods that you dislike: ______________________________

Any known food allergies? ☐Yes ☐No
If yes, please list these foods: ____

____

Do you follow a special diet now? ☐Yes ☐No

If yes, please explain
____

____

Have you ever followed a weight loss plan? ☐Yes ☐No

If yes, what type? ____

What did you like or dislike? ____

____

Did you feel it was successful? ☐Yes ☐No

Explain ____

____

Where do you typically shop for groceries? ____

What is your monthly grocery budget? ____

What is the number of people on average that you feed during the month? ____________________

Who prepares the meals for you or your family? ____

How many times do you typically eat out during the week? ____________________________

What are your favorite restaurants? ____

How often do you have a bowel movement? ____

Do you have problems with bowel movements? ____

Do you drink coffee? ☐Yes ☐No Cups per day: ______
Do you drink soda? ☐Yes ☐No Cups per day: ______

Describe your typical breakfast: ____

Describe your typical lunch:____

Describe your typical dinner: ____

What time do you typically eat dinner? ____

Do you snack during the day? ☐Yes ☐No What type of snacks do you consume? ______________

What time do you have your last snack? ______________________________

Goals

What are your health care goals? ______________________________

What is the most important health care goal? ______________________________

On a scare of 1 – 10, how willing are you to change your diet habits? ______________________________

What is your time frame of achieving these goals? ______________________________

How do you see me helping you achieve these goals? ______________________________

Do you need a support system? ☐Yes ☐No

What type of support system do you have to change your eating lifestyle? ______________________________

Health Assessment

Colon Health	
Feeling that bowels do not empty completely	☐0 ☐1 ☐2 ☐3
Lower abdominal pain relief by passing gas or stool	☐0 ☐1 ☐2 ☐3
Alternating constipation and diarrhea	☐0 ☐1 ☐2 ☐3
Diarrhea	☐0 ☐1 ☐2 ☐3
Constipation	☐0 ☐1 ☐2 ☐3
Hard, dry or small stool	☐0 ☐1 ☐2 ☐3
Coated tongue or "fuzzy" debris on tongue	☐0 ☐1 ☐2 ☐3
Pass large amount of foul smelling gas	☐0 ☐1 ☐2 ☐3
More than 3 bowel movements daily	☐0 ☐1 ☐2 ☐3
Use laxatives frequently	☐0 ☐1 ☐2 ☐3
Liver Health	
Greasy or high-fat foods cause distress	☐0 ☐1 ☐2 ☐3
Lower bowel gas and or bloating several hours after eating	☐0 ☐1 ☐2 ☐3
Bitter metallic taste in mouth, especially in the morning	☐0 ☐1 ☐2 ☐3
Unexplained itchy skin	☐0 ☐1 ☐2 ☐3
Yellowish cast to eyes	☐0 ☐1 ☐2 ☐3
Stool color alternates from clay colored to normal brown	☐0 ☐1 ☐2 ☐3
Reddened skin, especially the palms	☐0 ☐1 ☐2 ☐3
Dry or flaky skin and/or hair	☐0 ☐1 ☐2 ☐3
History of gallbladder attacks or stones	☐0 ☐1 ☐2 ☐3
Have you had your gallbladder removed?	☐0 ☐1 ☐2 ☐3
Blood Sugar Balance	
Crave sweets during the day	☐0 ☐1 ☐2 ☐3
Irritable if meals are missed	☐0 ☐1 ☐2 ☐3
Depend coffee to keep yourself going or to get started	☐0 ☐1 ☐2 ☐3
Get lightheaded if meals are missed	☐0 ☐1 ☐2 ☐3
Eating relieves fatigue	☐0 ☐1 ☐2 ☐3
Feel shaky, jittery or have tremors	☐0 ☐1 ☐2 ☐3
Agitated , easily upset or nervous	☐0 ☐1 ☐2 ☐3
Poor memory/forgetful	☐0 ☐1 ☐2 ☐3
Blurred vision	☐0 ☐1 ☐2 ☐3
Fatigue after meals	☐0 ☐1 ☐2 ☐3

Eating sweets does not relieve cravings for sugar	☐0 ☐1 ☐2 ☐3
Must have sweets after meals	☐0 ☐1 ☐2 ☐3
Waist girth is equal or larger than hip girth	☐0 ☐1 ☐2 ☐3
Frequent urination	☐0 ☐1 ☐2 ☐3
Increased thirst and appetite	☐0 ☐1 ☐2 ☐3
Difficulty losing weight	☐0 ☐1 ☐2 ☐3
Thyroid Health	
Tired or sluggish	☐0 ☐1 ☐2 ☐3
Feel cold, hands, feet or all over	☐0 ☐1 ☐2 ☐3
Require excessive amounts of sleep to function properly	☐0 ☐1 ☐2 ☐3
Increase in weight gain, even with a low calorie diet	☐0 ☐1 ☐2 ☐3
Gain weight easily	☐0 ☐1 ☐2 ☐3
Difficult, infrequent bowel movements	☐0 ☐1 ☐2 ☐3
Depression, lack of motivation	☐0 ☐1 ☐2 ☐3
Morning headaches that wear off as the day progresses	☐0 ☐1 ☐2 ☐3
Outer third of eyebrow is thinning	☐0 ☐1 ☐2 ☐3
Thinning of hair on scalp, face or genitals or excessive hair falling out.	☐0 ☐1 ☐2 ☐3
Dryness of skin and/or scalp	☐0 ☐1 ☐2 ☐3
Mental sluggishness	☐0 ☐1 ☐2 ☐3
Adrenal Health	
Cannot stay asleep	☐0 ☐1 ☐2 ☐3
Crave salt	☐0 ☐1 ☐2 ☐3
Slow starter in the morning	☐0 ☐1 ☐2 ☐3
Afternoon fatigue	☐0 ☐1 ☐2 ☐3
Dizziness when standing up quickly	☐0 ☐1 ☐2 ☐3
Afternoon headaches	☐0 ☐1 ☐2 ☐3
Headaches with exertion or stress	☐0 ☐1 ☐2 ☐3
Weak nails	☐0 ☐1 ☐2 ☐3
Cannot fall asleep	☐0 ☐1 ☐2 ☐3
Perspire easily	☐0 ☐1 ☐2 ☐3
Under high amounts of stress	☐0 ☐1 ☐2 ☐3
Weight gain when under stress	☐0 ☐1 ☐2 ☐3
Wake up tired even after 6 or more hours of sleep	☐0 ☐1 ☐2 ☐3
Excessive perspiration or perspiration with little or no activity	☐0 ☐1 ☐2 ☐3
Hyperacidity of Stomach	
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	☐0 ☐1 ☐2 ☐3
Stomach pain, burning, or aching 1 – 4 hours after eating	☐0 ☐1 ☐2 ☐3
Antacid use	☐0 ☐1 ☐2 ☐3
Feel hungry an hour or two after eating	☐0 ☐1 ☐2 ☐3
Heartburn when lying down or bending forward	☐0 ☐1 ☐2 ☐3
Temporary relief from antacids, food, milk, carbonated beverages	☐0 ☐1 ☐2 ☐3
Digestive problems subside with rest and relaxation	☐0 ☐1 ☐2 ☐3
Hypoacidity of Stomach	
Excessive belching, burping or bloating	☐0 ☐1 ☐2 ☐3
Gas immediately following a meal	☐0 ☐1 ☐2 ☐3
Offensive breath	☐0 ☐1 ☐2 ☐3
Difficult bowel movements	☐0 ☐1 ☐2 ☐3
Sense of fullness during and after meals	☐0 ☐1 ☐2 ☐3
Difficulty digesting fruits and vegetables – undigested food in stools	☐0 ☐1 ☐2 ☐3