Nutritional Assessment Questionnaire

Name _____ **Date** _____ **Birthdate** _____ **Gender** _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Part I

Read the following questions and fill in the number that applies:
Key: 0 (or leave blank) = Do not consume or use 2 = Consume or use weekly
1 = Consume or use 2-3 times/month 3 = Consume or use daily

Diet

1.	_____	Alcohol	8.	_____	Coffee	15.	_____	Refined Flour
2.	_____	Artificial Sweeteners	9.	_____	Fast Food	16.	_____	Refined Sugar
3.	_____	Candy or other sweets	10.	_____	Fried Foods	17.	_____	Vitamins/Minerals
4.	_____	Carbonated beverages	11.	_____	Luncheon Meats/Hot Dogs	18.	_____	Water, Distilled
5.	_____	Chewing Tobacco	12.	_____	Margarine	19.	_____	Water, Tap
6.	_____	Cigarettes	13.	_____	Milk Products	20.	_____	Water, Well
7.	_____	Cigars/Pipes	14.	_____	Non-Herbal Tea	21.	_____	Do You Diet Often?

Lifestyle

22. _____ Times you exercise per week (1=once a week, 2 = 2-4 times per week, 3 = 3-5 times per week)
23. _____ Changed jobs (3 = within last 2 months, 2 = within last 6 months, 1= within last 12 months)
24. _____ Divorced (3 within last 6 months, 2 = within last year, 1 = within last 2 years)
25. _____ Work over 60 hours per week (3 = always, 2 = usually, 1 = occasionally, 0 = never)

Medications

Indicate with a checkmark or circle any medications you're currently taking or have taken in the last month:

26.	_____	Antacids	35.	_____	Cortisone	43.	_____	Insulin
27.	_____	Antibiotics	36.	_____	Diabetic medications	44.	_____	Contraceptives
28.	_____	Anticonvulsants	37.	_____	Diuretics	45.	_____	Radiation Exposure
29.	_____	Antidepressants	38.	_____	Estrogen/Progesterone	46.	_____	Recreational Drugs
30.	_____	Antifungals	39.	_____	Heart Medications	47.	_____	Relaxants/Sleeping Pills
31.	_____	Aspirin/Ibuprofen	40.	_____	High Blood Pressure	48.	_____	Thyroid Medication
32.	_____	Asthma Inhalers	41.	_____	Hormone Therapy	49.	_____	Tylenol/Acetaminophen
33.	_____	Beta blockers	42.	_____	Laxatives	50.	_____	Ulcer Medications
34.	_____	Chemotherapy						

Other medications and dosages (if known): _____

_____

Part II

Read the following questions and fill in the number that applies:
0 (or leave blank) = No or do not have the symptom, the symptom does not occur
1= Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
2= It is a moderate symptom or it occasionally occurs (weekly)
3= It is a severe symptom or it frequently occurs (daily)

Section 1 — Upper Gastrointestinal System

51.	_____	Belching or gas within 1 hour of a meal	61.	_____	Do you feel like skipping breakfast?
52.	_____	Heartburn or acid reflux	62.	_____	Do you feel better if you don't eat?
53.	_____	Bloating shortly after eating	63.	_____	Sleepy after meals
54.	_____	Are you a vegan (no dairy, meat, fish or eggs)	64.	_____	Fingernails chip, peel or break easily
55.	_____	Bad breath (halitosis)	65.	_____	Anemia
56.	_____	Loss of taste for meat	66.	_____	Stomach pains or cramps
57.	_____	Sweat has a strong odor	67.	_____	Diarrhea, chronic
58.	_____	Stomach upset by taking vitamins	68.	_____	Diarrhea shortly after meals
59.	_____	Sense of excess fullness after meals	69.	_____	Black or tarry stools
60.	_____	Undigested food in stool			

Fisher Wellness Center
Client Agreement

1. I fully understand that the Holistic Health Practitioner, _____, is not treating any disease or health condition. If I have a disease, health problem or health condition I am now being advised to seek qualified medical advice from a licensed physician.
2. I understand that the above named practitioner teaches clients how to build their own health through training in the effective use of lifestyle modification, pollution avoidance, clean air, pure water, proper foods, rest, exercise, medication, goal orientation, positive mental attitudes, stress reduction techniques, and adjustments both physical and spiritual of social and economic factors affecting over-all health.
3. The use of exercises, finger pressure, thumb pressure, massage or movements demonstrated on the body of the client are examples which can be performed by the client in the privacy of his/her own home. Demonstration for muscle tone or circulation of vital life force energy (as defined by acupuncturists) for greater fitness levels are NOT to be construed as treatment for any disease or health conditions.
4. Recommendations, suggestions and references to meals, menus or nutritional supplements are for body building, increased stamina and energy and general health maintenance and do NOT involve any diagnosing, prognosticating or prescribing for the treatment of any disease or health condition.
5. I have read and understand what is written above. My signature below signifies that I agree to retain the above named Holistic Health Practitioner to educate me through lecture, testing evaluation and demonstrations, in methods available for me to help myself to the improvement of my overall general health.
6. I am here as a client, on this or any subsequent visit, solely on my own behalf and not as an agent for federal, state or local agencies on a mission of entrapment or for any investigative purposes.

Date _____ Client Signature _____

Home Phone _____ Address _____

Cell Phone _____ City, State, Zip _____

Date of Birth _____ Email Address _____

Medical Information

Current medical problems _____

_____

_____

_____

_____

_____

Are you currently under the care of a physician? _____

If so, please give your physician's information below.

Name _____

Address _____

Address _____

City, State, Zip _____

Phone Number _____

List any other pertinent information which you think is essential.

_____

_____

_____