Nutritional Questionnaire

Name ____ Date _____________________________

Current Complaint ____

Supplements/Vitamins currently taking ____

Food Sensitivities/Allergies Yes/No ____

Do you do any forms of exercise or stretching Yes/No __________________________________

To the best of your knowledge: Height __________ Weight _____________

Circle the Corresponding Number

1. Rarely or never experience the symptom
2. Occasionally experience the symptom/Effect is not severe
3. Frequently experience the symptom/Effect is not severe
4. Frequently experience the symptom/Effect is severe

Joints/Muscles

Pain or aches in joints 0 1 2 3 4

Arthritis 0 1 2 3 4

Stiffness/Limited movement 0 1 2 3 4

Poor circulation 0 1 2 3 4

Digestion

Nausea and/or vomiting 0 1 2 3 4

Indigestion 0 1 2 3 4

Bloated Feeling 0 1 2 3 4

Belching and/or pass gas 0 1 2 3 4

Heartburn 0 1 2 3 4

Stress

Anxiety/Nervousness 0 1 2 3 4

Depression 0 1 2 3 4

Insomnia 0 1 2 3 4

Anger/Irritability 0 1 2 3 4

Elimination

IBS/Colitis 0 1 2 3 4

Diverticulitis 0 1 2 3 4

Constipation 0 1 2 3 4

Diarrhea 0 1 2 3 4

Immune

Frequent colds/flu 0 1 2 3 4

Allergies/Sinus 0 1 2 3 4

Frequent use of antibiotics 0 1 2 3 4

Food allergies 0 1 2 3 4

Hormone

Menstrual/PMS 0 1 2 3 4

Menopause symptoms 0 1 2 3 4

Prostate symptoms 0 1 2 3 4

Fatigue 0 1 2 3 4