Certified Nutrition Consultant
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Nutrition and Integrative Health Adult Questionnaire

Instructions for your first nutrition consultation

Thank you for taking the time to thoughtfully answer the questions in this new client questionnaire. You'll have ample opportunity to address any concerns that require more detail during your appointment.

Required for your first visit:

1. The completed new client questionnaire, along with the 3-Day Diet Diary included in the questionnaire.

   Instructions for completing the 3-Day Diet Diary:

   - Record information as soon as possible after the food has been consumed. Please include all beverages, even water.
   - Include the time that you ate each meal/snack.
   - Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
   - Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
   - Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
   - Include any additional items (i.e. condiments). For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.

2. Please send any labs, blood tests or other pertinent medical information you think may be helpful prior to your appointment.

Please bring the following:

- Any pharmaceuticals, over-the-counter drugs, and/or supplements you are taking – please bring them in their original containers so your clinical intern can determine what ingredients and amounts are in the products.

If you have any questions please contact me at cara@carazaller.com.

NUTRITION

Adult Questionnaire

Client confidentiality will be maintained at all times. The information provided on this questionnaire may only be disclosed with the express written consent of the individual named herein or, if under the age of 18, his or her legal guardian.

Please allow 30-45 minutes to complete most of this questionnaire. The 3-day diet diary will require you to record your food and beverage intake over a 3-day period. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you. That said; please answer only the questions you are comfortable answering.

Basic Information

Primary Physician's Name:________________________________ Physician Office Number: __________________

Physician Address:______________________________________ Physician Fax Number: ____________________

Today's Date: _________________

Contact Information			
Name:		Address:	
Work phone:		Home phone:	
Mobile phone:		Email:	
Preferred contact method:		Best time(s) of day to reach you:	

Emergency Contact					
Name:		Relationship:		Phone:	

Occupation & Interests					
Occupation:		How long?		Satisfied? (1-10)	
What are your interests/passions:					

Demographics									
Age		Date of Birth		Gender		Race		Ethnicity	
Height:		Weight	lbs.	Highest Adult Weight	lbs. / Yr.:			Lowest Adult Weight	lbs. / Yr.:

Relationship Information					
Status		Partner's Name:		Partner's Gender:	

Personal Information			
Religion:		Education:	
With whom (persons or animals) do you share your home?			

What types of health practitioners are you currently working with?

What would be your primary reasons for coming to a nutritionist?

1.
2.
3.

Medical Information

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

Has your doctor diagnosed you with a medical condition (s)?_____If so, please list:

Are you part of a recovery program?_____If so, which one?

Do you have any allergies to foods, medications, chemicals, and/or other environmental substances? ____
If so, to which ones?

What is your typical reaction and how severe is it (1-10)?

What, if any, surgeries/operations have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations? ____
If so, when and for what reason(s)?

Have you ever had a major chemical exposure?_____If so, when and to what?

Where and when have you lived or traveled outside of the U.S. and Canada?

Is there anything that surfaced during a recent medical test, lab work, or doctor's visit that you would like to report?

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children/ages		

Medications & Supplements

Current Medications (Over-the-Counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking
What medication have you taken in the past for a considerable amount of time?				

Current Dietary or Herbal Supplements					
Name	Brand	Dosage	Frequency	Length of Time	Reason for Taking

For Women

Pregnancies *(please include losses/terminations)*			
Year	Vaginal/C Section	Sex	Complications/Other Things You Want to Mention

Are you currently pregnant?______

Are you actively trying to conceive?___

Are you breastfeeding?____

PHYSICAL ACTIVITY					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Active lifestyle					Examples?
Cardio type exercise					What type(s)?
Strength building exercise					What type(s)?
Stretching					What type(s)?
How would you categorize your activity level?		_____Sedentary______Mildly Active______Moderately Active _____Very Active______Intensely Active			

SLEEP	
At what time are you typically in bed?	
What time do you fall asleep?	
Typical hours asleep?	
# of times you awaken during the night	
Reason(s) why you wake during the night	
Do you feel rested upon rising?	

LIFESTYLE					
	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Sexual Activity					
Socializing w/Friends					
Relaxation/Self Pampering					What type(s)?
Tobacco					What type(s)?
Recreational Drugs					What type(s)?
Teeth Flossing					

STRESS							
On a scale of 1-10, with 1 being low and 10 being high, how stressful is your:							
Work:		Social/family situation:		Current health status:		Life in general:	
Do you feel that your current state of health is:		largely in your control or largely out of your control					
What do you believe you can do to make a difference in your current health status?							
If so, what 1-2 key steps have you already taken?							

Moods You Experience Frequently

accepting	anxious or nervous	angry	capable	compassionate
determined	dreadful	empowered	enthusiastic	fortunate
guilty	happy	hopeful	hurt	inspired
lonely	loved	peaceful	resentful	resigned
sad	scared	terrified	tired	uncertain

Significant Life Events

Please list major events in the last ten years of your life and the dates they occurred. Include illness, medical condition, births, deaths, marriage, divorce, accidents, moves, jobs changes, miscarriages, and anything else you feel greatly impacted your life.

Date	Event

Metabolic Screening Questionnaire

Use this questionnaire to chart your health and progress. Rate each of the following symptoms based on your health for the past thirty days.

Point Scale:
0 = Never or almost never have the symptom. 1 = Occasionally have it; effect is not severe. 2 = Occasionally have it; effect is severe.
3 = Frequently have it; effect is not severe.
4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

Digestive Tract

_______Nausea or vomiting
_______Diarrhea
_______Constipation
_______Bloated feeling
_______Belching or passing gas
_______Heartburn
_______**Total**

Ears

_______Itchy ears
_______Earaches, ear infections
_______Drainage from ear
_______Ringing in ears, hearing loss
_______**Total**

Emotions

_______Mood swings
_______Anxiety, fear, or nervousness
_______Anger, irritability or aggressiveness
_______**Total**

Energy/Activity

_______Fatigue, sluggishness
_______Apathy, lethargy
_______Hyperactivity
_______Restlessness
_______**Total**

Eyes

_______Watery or itchy eyes
_______Swollen, reddened, or sticky eyelids
_______Bags or dark circles under eyes
_______Blurred or tunnel vision
_______Slurred speech
_______**Total**

Mouth/Throat

_______Chronic coughing
_______Gagging, frequent need to clear throat
_______Sore throat, hoarseness, loss of voice
_______Swollen or discolored tongue, gums, lips
_______Canker sores
_______**Total**

Nose

_______Stuffy nose
_______Sinus problems
_______Hay fever
_______Sneezing attacks
_______Excessive mucus formation
_______**Total**

Head

_______Headaches
_______Faintness
_______Dizziness
_______Insomnia
_______**Total**

Heart

_______Irregular or skipped heartbeat
_______Rapid or pounding heartbeat
_______Chest Pain
_______**Total**

Joints/Muscles

_______Pain or aches in joints
_______Arthritis
_______Stiffness or limitation in movement
_______Pain or aches in muscles
_______Feeling of weakness or tiredness
_______**Total**

Lungs

_______Chest congestion
_______Asthma, bronchitis
_______Shortness of breath
_______**Total**

Mind

_______Poor memory
_______Confusion, poor comprehension
_______Poor concentration
_______Difficulty in making decisions
_______Stuttering or stammering
_______Learning disabilities
_______**Total**

Skin

_______Acne
_______Hives, rashes, or dry skin
_______Hair Loss
_______Flushing or hot flashes
_______Excessive sweating
_______**Total**

Weight

_______Binge eating/drinking
_______Craving certain foods
_______Excessive weight
_______Compulsive eating
_______Water retention
_______Underweight
_______**Total**

Other

_______Frequent illness
_______Frequent or urgent urination
_______Genital itch or discharge

_______**Grand Total**

Symptom Questionnaire Please place **yes or no** after each question.

Section 1	
Indigestion, burping, bloating or sleepy immediately after meals	
Heartburn or acid reflux symptoms	
Tendency to allergies, eczema, asthma	
Nausea in evenings	
Proteins hard to digest, complex meals hard to digest (combination of proteins and carbs)	
Loss of taste for meat	
Sense of excess fullness after meals	
Feel like skipping breakfast, overall low appetite	
Undigested food in stool	
Anemia, unresponsive to iron	

Section 2	
Heartburn or acid reflux symptoms	
Nausea in mornings	
Strong appetite, demanding hunger, excess salivation	
Aggravated by spice or sour, sour burps, sour smell	

Section 3	
Pain between shoulder blades	
Stomach upset by fatty or fried foods	
Loose stools with fatty foods, irregular stools, fat in stools (shiny, floating), smelly stools	
Nausea	
Light, clay colored or greenish/yellow stools	
Dry skin, itchy feet or skin peels on feet	
Gallbladder attacks	
Gallbladder removed	
Bitter taste in mouth, especially after meals	
Easily intoxicated or hung if you were to drink wine	
Pain under right side of rib cage	
Hemorrhoids or varicose veins	
Sensitive to chemicals (perfume, cleaning agents, etc.), diesel fumes or tobacco smoke	

Section 4	
Food allergies or sensitivities (wheat or grain, or dairy or other)	
Frequent intake of allergenic food (s), strong attachment to allergenic foods	
Craving, addiction or binging of allergenic foods (s)	
Abdominal bloating 1-2 hours after eating	
Pulse speeds up after eating	
Crohn’s disease, frequent sinus infection, migraines, asthma	
Airborne allergies	
Experience hives	

Section 5	
Catch colds at the beginning of winter	
Frequent colds, flu or other infections (sinus, ear, bladder, skin, etc.)	
Experienced a mucous producing cough	
Never get sick	
History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis, or other chronic viral conditions	
Have food allergies or sensitivities	

Section 6	
Coating on your tongue	
Anus itches	
Fungus or yeast infections	

Yeast symptoms increase with sugar, starch or alcohol consumption	
Less than one bowel movement a day	
Constipation, stools hard or difficult to pass	
Excessive foul smelling lower bowel gas	
Irritable bowel or mucous colitis	
Bad breath or strong body odor	
Cramping in lower abdominal region	
Stools are difficult to pass	
History of parasites	
Stools have corners or edges, are flat and ribbon shaped	

Section 7	
Eat less than five servings of (one-half cup cooked, 1 cup raw) of colored vegetables or fruits a day	
Crave sweets, breads, rolls, cookies, pasta, pizza or chips	
Crave coffee or sugar in the afternoon	
Sleepy in the afternoon	
Fatigue is relieved by eating	
Binging or uncontrolled eating	
Excessive appetite	
When you eat snacks/sweets, do you eat them, get a temporary boost of energy and mood, and later crash?	
Headache, irritability or shakiness if meals are skipped or delayed	
Heart palpitations after eating sweets	
Have frequent thirst	
Have frequent urination	
Once you start eating sweets or carbohydrates, do you feel you can't stop	
Tend to gain weight in the belly	
Have pre-diabetes, diabetes, PCOS, hypoglycemia or alcoholism or a family history of any one of these	
Have elevated triglycerides or cholesterol	
Have high blood pressure	

Section 8	
Have high or low blood pressure	
Have a low libido	
Have trouble falling asleep	
Get less than 8 hours a sleep a night	
Go to bed frequently after midnight	
Get less than 1 hour a day of sunlight	
Work the night shift	
Are you an emotional eater	
Feel anxious or have panic attacks	
Are you a shallow breather	
Experience heart palpitations	
Cravings for salt or sweets	
Experience chronic or prolonged fatigue	
Does fatigue prevent you from doing things you would like to do. Interfere with you work, family or social life	
Do you feel you can't get started in the morning without coffee or caffeinated drinks	

Section 9	
Are you cold when everyone else is warm	
Have course or brittle hair	
Experience constipation	
Have thinning hair or hair loss	
Experienced a loss of sex drive	
Lost the outside of your eyebrow	
Experience depression	
Have trouble losing weight	
Have a low blood pressure or heart rate	
Have elevated cholesterol	
Have a hoarse voice	

Have dry, scaly skin	
Have cold hands and feet	
Experience fatigue	
Experience fluid retention	

Section 10	
Aware of irregular or heavy breathing	
Experienced discomfort at high altitudes	
Sigh frequently or “air hunger”	
Have shortness of breath with moderate exertion	
Experience swelling of the ankles, especially at end of day	
Blush or face turns red for no reason	
Experience a dull pain or tightness in chest and/or radiate into left arm, worse on exertion	
Have muscle cramps on exertion	

Section 11	
Rarely break out into a sweat	
Use aluminum cooking equipment	
Have mercury amalgams	
Heat food in plastic containers in microwave	
Have your clothes dry-cleaned	
Eat “fast-food” > 2 times a week	
Drink tap, well or bottled water	
Have strong body odor	
Have acne on face or buttocks	
Drink < 4 cups water a day (approximately 30 oz)	
Live in a large urban or industrial area	
Use lawn or garden chemicals	
Have less < 1 bowel movement per day	
React to small amounts of alcohol	
Sit on your computer 3+ hours a day	
Exercise < 3 times a week	
Use tobacco products	
Eat large fish (sword fish, tuna, shark, tilefish) more than once a week	
Urinate small amounts of dark urine only a few times a day	
Frequently exposed to solvents and chemicals at work or at home	
Feel any of the following: wired, increased aches in muscles and joints, anxiety, palpitations, sweating, dizziness when using caffeine	
Have a negative reaction when you consume foods containing MSG, sulfites or other preservatives	

NUTRITION FREQUENCY					
Food/Drink	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Caffeine					In what form?
Soda/Soft Drinks (diet or regular)					What type(s)?
Alcohol					What type(s)?
Herb tea					What type(s)?
Red Meat					_____Beef,_____Lamb, _____Sausage/deli
White Meat					_____Beef,_____Lamb, _____Sausage/deli
Eggs					
Fish/Shellfish					
Nuts & Seeds					
Fruits					_____Canned,_____Fresh, _____Frozen
Vegetables					_____Canned,_____Fresh, _____Frozen
Lentils & Beans					_____Canned,_____Fresh, _____Frozen
Oils / fats (e.g., olive, butter)					What type(s)?
Dairy Products					_____Milk,_____Yogurt, _____ Cheese,_____Butter
Soy Products					What type(s)?
Whole grains					What type(s)?
Grain-based products					_____Bread,_____Pasta, _____Crackers
"Junk / Fast Food"					What type(s)?
Fried Foods					What type(s)?
Artificial Sweeteners					_____Aspartame,_____Equal _____Sucralose,_____Truvia
Chewing Gum					What type(s)?
How many times each week do you eat each meal at home (vs. out)?				_____Breakfast,_____Lunch,_____Dinner	
Approximately how many **ounces** of water do you drink per day?				_____oz_____Bottled,_____Filtered,_____Tap	

Nutrition - 3-Day Food Diary Record information as soon as possible after the food has been consumed. Please include all beverages, even water. (Please include the time, approximate quantity and mood)		
Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Thank you for taking the time to complete this questionnaire.