cara zaller

real food. real results.

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? ____

For Everyone

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