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HEALTH AND NUTRITION QUESTIONNAIRE

Please fill out this questionnaire to the best of your ability. It will help to assess your nutritional status and develop an individualized plan to meet your needs.

NAME:_____ DATE:_____

ADDRESS:_____CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

DATE OF BIRTH:_____ AGE:_____ EMAIL:_____ REFERRED BY:_____

MARRIED?_____ # OF KIDS_____ OCCUPATION:_____ WORK HOURS:_____

HEIGHT:_____ WEIGHT:_____ USUAL WEIGHT:_____ GOAL WEIGHT:_____

Do you have any of the following? Please check all that apply.

Health Condition	**Do you have? Yes or No Describe**	**Family History? List family member**
Type 1 Diabetes		
Type 2 Diabetes		
High Blood Pressure		
High Cholesterol		
Heart Conditions		
Thyroid Condition		
Liver Conditions		
Kidney Conditions		
Digestive Disorders		
HIV		
Pregnant/ Nursing		
Infertility/ Miscarriages		
Cancer/ Chemotherapy		
Chronic pain		
Depression/ Anxiety		
Eating Disorder		

Any other diagnosis not listed above: (Please specify)_____

Are you currently taking any *prescriptions* or *over the counter medications*? Please explain.

_____

_____

Are you currently taking any *vitamins, minerals, or food supplements*? Please explain.

_____

SYMPTOMS:

In the last 90 days have you struggled with any of the following:

_____Weight gain or inability to lose weight

_____Food cravings (i.e. sugar, salt, coffee, alcohol)

_____Gas or bloating

_____Reflux

_____Bowel movements (not daily, hard to pass, or not fully eliminating)

_____Headaches or migraines

_____Pain in the neck or back

_____Swollen joints

_____Difficulty focusing or loss of attention

_____Trouble falling or staying asleep

_____Waking tired in the morning, regardless of how many hours you've slept

_____Fatigue in the afternoon around 3PM

_____Heavy periods or irregular periods

_____Hot flashes or night sweats

_____Mood shifts for no reason

_____Anxiety or depression

_____Acne, psoriasis or eczema

_____Allergies to grass/ trees/ pollen/ mold/ chemicals/ perfumes **If yes, fill in box below

_____Allergies to foods**If yes, fill in box below

Check any of the substances you believe may be causing your problems

_____Shell Fish	_____Dairy (milk, cheese, yogurt, etc)	_____Coffee, Chocolate, Tea (caffeine)	_____Sunlight	_____Stinging Insects
_____Wine, Beer, Alcohol	_____Nightshades (tomatoes, potatoes, peppers)	_____Laundry Detergents, Softeners	_____Antibiotics	_____Chemicals _____
_____Fruits/ Berries	_____Grains	_____Fabrics, Upholstery, Plastics	_____Metals	____Drugs _____
_____Nuts/ seeds	_____Herbal Remedies	_____Latex	_____Environmental (pollen, grass, mold)	
_____Eggs	_____Nutritional Supplements	_____Perfumes, Candles, Oils	_____Animal Dander, Feathers, Fur	

NUTRITION GOALS:

List your top 3 chief complaints/ health concerns

1. _____
2. _____
3. _____

What is your goal and/ or desired outcome?_____

_____

How long do you think it will take to reach your goal?:_____

DIETARY HISTORY:

Have you ever been on a special diet? Please specify._____

_____

What methods of weight management have you previously tried?_____

_____

Does anyone in your household follow a special diet? Please specify._____

How many times/ day do you eat?	__Less than 3	__3	__4-5	__More than 5
How many cups (8 ounces) of coffee do you drink/ day?	__0	__1	__2	__3 or more
How many sodas (8 ounces) do you drink/ day?	__0	__1	__2	__3 or more
How many glasses (8 ounces=1 cup) of water do you drink /day?	__8-16 ounces (1-2 cups)	__17-40 ounces (3-5 cups)	__40-63 ounces (5-7 cups)	__64 ounces or more (8+ cups)
How many glasses (8 ounces=1 cup) of milk do you drink /day?	__1 cup	__2 cups	__3 cups	___4 or more cups

When you eat away from home, where do you eat most often? (Check all that apply)

Restaurant_____ Grocery Store_____ Brown Bag_____

Fast Food_____ Cafeteria_____ Other_____

How often do you eat away from home?_____ # of household members_____ Who prepares the meals?_____ Who does the grocery shopping?_____ How often?_____

ACTIVITY:

Describe your exercise program, if applicable. What do you do? How often?_____

Physically, do you consider your work: Very Active_____ Moderately Active_____ Light_____ Sedentary_____

Do you have a medical or physical condition that affects your diet or your ability to exercise?

_____

Informed Consent

Living Well, LLC, Amy Richardson, Certified Nutrition Therapist (CNT) and Megan Magee, Registered Dietetic Tech (DTR) are not medical doctors. I understand that Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) do not claim to diagnose, treat, cure, or prevent any medical conditions or pathologies, nor prescribe medicine, nor in any way represent as so doing. The services of a Nutrition Professional cannot replace those of a licensed physician. For any medical condition, you are advised to seek care from an appropriate medical practitioner. Whether you choose to engage a medical practitioner or not, to assist you in your care is your right and Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) assume no responsibility for your decision in this matter. I have informed Living Well of all my known physical conditions, medical conditions, and medications, and I will keep them informed of any changes.

I, the undersigned, assume all responsibility for decisions I make regarding my health, recognizing that (a) no claims are made that herbal, nutritional, or dietary recommendations can treat or cure any medical condition, (b) all recommendations are given for informational purposes only, (c) there is no implied or stated guarantee of success or effectiveness of any specific dietary, nutritional, or herbal recommendations, (d) I am free to act upon or disregard the recommendations of Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) as I so choose. I hereby release Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) from all responsibility for my actions and any consequences thereof in the present time and in the future with no constraints. I hereby affirm that I consent and agree to the above statements of my own free will and request to engage in the services offered by Living Well, LLC, Amy Richardson, (CNT) and Megan Magee, (DTR) and participate in a professional relationship with them pursuant to the statements herein.

Client's Name (print) Client's Signature Date

If Minor, Client's Representative (print) Signature of Client's Rep. Relation to Client Date