Nutrition Works, Inc.

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Nutrition Works, Inc.

Adult Intake Questionnaire

To enhance your scheduled consult time, please have this back to us at least 1 day prior to your appointment, if possible. You can scan and email it to me: Traci@hudsonvalleynutritionworks.com. If you have any questions, please call me at 914-474-3795.

Name_____Today's date_____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Fax Number: (_____)_____-_____

Home Phone:(_____)_____-_____Work:(_____)_____-_____Cell:(_____)_____-_____

Birthdate ____/____/_____ (month day year) Age: _____ Place of Birth :_____ (city/town (and country if not in US))

Occupation: _____ Referred by: _____

Height: _____' _____" Weight: _____ Desired Weight: _____ Last Age at Desired Weight: _____

Highest Adult Weight:_____What Age?: _____Lowest Adult Weight: _____What Age?: _____

Have you ever dieted?: r Yes r No If Yes, how many times in your adult life? _____

Which diet(s) worked: _____

Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			

PAST MEDICAL AND SURGICAL HISTORY:

3. **ILLNESSES**	**WHEN**	**COMMENTS**
a. Anemia (type)		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Sinusitis		
w. Sleep Apnea		
x. Stroke		
y. Thyroid disease		
z. Other (describe)		
INJURIES		
ab. Back injury		
ac. Broken Bones		
ad. Head Injury		
ae. Neck Injury		
af. Other (acute) ex: sprained muscle		
ag. Other (chronic) ex: bad knees		
OPERATIONS		
ao. Dental Surgery		
ap. Gallbladder		
aq. Hysterectomy		
ar. Tonsillectomy		
as. Other (describe)		

Did you have any health issues as a child? __No __Yes - What age?_____
Describe:_____
_____
_____

As a **child,** where there foods you avoided? __No __Yes-(please specify below)

Food	Symptoms
Ex: Milk	Ex: Gas and diarrhea

Please mark in the chart below with information about recent bowel movements:

Frequency:		**Color:**	
More than 3 times a day		Dark brown	
2-3 times a day		Medium brown	
One time per day		Very dark or black	
4-6 times a week		Greenish	
2-3 times a week		Blood is visible	
Once or fewer a week		Varies a lot	
Consistency:		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose, but not watery			
Alternating between hard and loose/watery			

Do you experience intestinal gas? (check all that apply)
__present with pain __foul smell __little odor __excessive daily __occasionally

Do you experience anal itching? __frequently __occasionally __rarely __never

Do you experience any heartburn, chest pressure, or stomach pain? __No __Yes
If yes, do you take anything for relief (list):
_____
_____

Do you have any chronic skin condition or issues? e.g.-rash,eczema __No __Yes

MEDICATIONS:

What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

Medication Name	Purpose	Dosage	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

List all vitamins, minerals, and other nutritional supplements that you are currently taking.
Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

Vitamin/Herbal Supplement(s)	Brand	How Many and When?	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

********Please have bottles with you at your appointment********

DIETARY HABITS:

Are you currently on a special diet (i.e.-gluten-free, Paleo, dairy-free etc)? __No __Yes
If yes, how long and describe:_____
_____

Usual Breakfast time:_____Lunch time:_____Dinner time:_____ Snack time: _____ Snack time: _____ Snack time:_____

Place a mark next to the food/drink that applies to a typical day of your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner	Usual Snacks
None	None	None	None
Cereal	Eat in cafeteria	Pasta	Nuts
Wheat Bran	Eat in restaurant	Potato	Fruit
Oatmeal	Leftovers	Brown rice	Vegetables
Toast	Meat sandwich	White rice	Pretzels
Bagel	Fish sandwich	Beans (legumes)	Potato Chips
Sweet roll	Lettuce (on sandwich)	Fish	Corn Chips
Donut	Tomato	Red Meat	Crackers
Eggs	Salad	Poultry	Cheese
Bacon/Sausage	Salad dressing	Salad	Cookies
Fruit	Soup	Salad dressing	Cake/Pastries
Yogurt	Fruit	Green vegetables	Nut butters
Milk	Yogurt	Carrots	Cereal
Juice	Milk	Yellow vegetables	Ice cream
Tea	Juice	Milk	Trail mix
Coffee	Tea	Juice	Dried fruit
Water	Coffee	Tea	Other: (list)
Butter	Water	Coffee	
Margarine	Regular soda	Water	
Sugar	Diet soda	Regular soda	
Sweetener	Butter	Diet soda	
Leftovers	Margarine	Butter	
Other:	Mayonnaise	Margarine	
	Sugar	Sugar	
	Sweetener	Sweetener	
	Other:	Other:	

Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.? __No __Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea)_____
_____
_____
_____

Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*
__No __Yes
If yes, specify: _____
_____

How much of the following do you consume on average?

Food	Amount Per Day	Amount Per Week
Candy		
Cheese		
Chocolate		
Cups of caffeinated coffee		
Cups of decaffeinated coffee		
Cups of hot chocolate		
Cups of tea (containing caffeine)		
Diet sodas (cans)		
Regular soda (cans)		
Ice cream		
Salty snacks		
Slices white bread/rolls/1/2 bagel		
Nuts		

Do you feel **much worse** when you eat any of the following: (check all that apply)
__high fat foods __refined sugar (junk foods) __high protein foods __fried foods
__high carbohydrate foods __1 or 2 alcoholic drinks
__(breads, pastas, potatoes) __Other (specify):_____

Do you feel **much better** when you eat a lot of: (check all that apply)
__high fat foods __refined sugar (junk foods) __high protein foods __fried foods
__high carbohydrate foods __1 or 2 alcoholic drinks
__(breads, pastas, potatoes) __Other (specify):_____

Do you feel **worse** at certain times of the year? __No __Yes-(when?_____)
How do you feel?_____

Do you feel **better** at certain times of the year? __No __Yes-(when?_____)
How do you feel?_____

Does skipping a meal affect you in any way? __No __Yes – Explain: _____
_____
_____

Do you ever crave or "binge" on certain foods? __No __Yes
Which foods, how often and comment on possible stressors/triggers? _____
_____
_____
_____
_____

Do you avoid certain foods for any reason? __No __Yes
Which foods and why?_____
_____
_____
_____
_____

Food Frequency List

Please indicate the **approximate number of times** you have eaten these foods in a typical week. For each section you may **cross out** food/beverages seldom consumed, and **circle** foods/beverages you do eat.

Consumed in the past 7 days	Number of Times	Consumed in the past 7 days	Number of Times
Vegetables: Dark green leafy: spinach, Romaine, leaf lettuce, Caesar Salad, etc.		**Fish: (list):** fresh, fried or canned?	
Iceberg lettuce or **bagged salad combos**, celery cucumbers, zucchini		**Poultry: Chicken:** dark meat, breast **Turkey:** dark meat, breast, lunch meat, turkey bacon	
Broccoli, Brussels sprouts, cabbage/coleslaw, kale, turnip or mustard greens		**Beef:** hamburgers, steak meatloaf, stew, chili Is it usually regular, lean, grass fed or organic?	
Fresh/frozen **mixed** veggies: corn, green beans, peas		**Pork:** ham, sausage, bacon	
Yellow-orange veg: carrots, squash, sweet potatoes		**Hot dogs:** beef or turkey, bratwurst, italian sausage, etc.	
Tomatoes, pasta sauce, tomato juice, V-8, salsa, etc		**Fried foods:** fries, chicken, etc.	
Fresh vegetable juices:		**Lunchables®, bologna, salami,** etc.	
Other: ORGANIC?		**Vegetarian foods: (list):**	
		Indian Vegetarian foods: (list):	
Fruits: (circle): banana, pear, apple, grapes, kiwi **Other:**		**Beans, legumes, peas:** bean/lentil soup, bean burritos, veg chili, split pea soup, etc.	
Berries (list):		Vegetarian foods: (list):	
Canned/jar fruit: applesauce, pears, peaches		**Veggie burgers, TVP, tofu, tempeh, seitan, Quorn® products, etc.**	
Dried fruits:		**Raw nuts/seeds:** almonds, sunflower seeds, pecans, walnuts, etc.	
Wheat bread: rolls, buns, sandwiches, pita, bagel White, whole grain, low carb, spelt, Ezekiel®		**Trail mix**, roasted salted nuts	
Cold cereal (list):		**Peanuts**, peanut butter, **almond** butter, tahini, etc	
Hot cereal (list):		**Protein** powders: **soy, whey, egg or rice?**	
Pancakes, waffles **tortillas**: corn or flour		**Protein:** liquid (ready-to-drink)	
Muffins, donuts, sweet rolls, granola bars		**Flax** seed meal or flax oil, **cod liver oil**?	
Pretzels, crackers, etc.		**Butter:** ORGANIC?	
Gluten-free foods:		**Margarine: (list brand):**	
Rice:		**Potato chips**, Fritos®, Doritos®, Pringles®, etc.	
Potatoes: mashed, boiled or bakes? Red or white?		**Popcorn: prepackaged or homemade?**	
Pasta: spaghetti, lasagna, macaroni, pasta salad, etc.		**Candy (list):**	
		Pie, cake, cookies, other snacks (list):	
Eggs: whole or whites only?		**Gum**, breath mints: regular or sugarless?	
Dairy: Cow's milk: skim, 2%, or whole? **ORGANIC?**		**Coffee/espresso drink**? Regular or decaf? # of 8oz cups?	
Yogurt, cheese, nachos, cottage cheese **ORGANIC?**		**Tea:** black, green, white, herbal infusion.	
Pizza: sausage, peperoni, vegetable, etc.		**Sugar or no/low calorie sweetener? (list):**	
Ice cream, frozen yogurt, shakes, malts, etc.		**Soda pop: regular or diet? (list):**	
Soy milk, **goat** milk, **rice** milk, **almond** milk		**Alcohol** beverage: wine, beer, hard liquor	
Circle other frequent foods: Frozen/microwave meals: Weight Watchers®, Lean Cuisine®, Healthy Choice®, Mexican cuisine, Indian cuisine, Chinese/Thai, Vegetarian, Atkins®, Low carb, SlimFast®, etc.			
Average daily water intake in 8 oz glasses (not counting soda pop or coffee): 1-2 3-4 5-6 7-8 9-10 Is it: **tap water, filtered tap water, spring water, distilled, etc.?**			

COMMENT SECTION:

Anything else you think I should know?