

INDIVIDUAL HEALTH PROFILE QUESTIONNAIRE

**Lifestyle Fitness & Nutrition**

**3708 Fairways Court**

**Fredericksburg, VA 22408**

**Phone: (540) 898-5219**

**Fax: (540) 891-4050**

##### E-mail: dphetrick@verizon.net

# Basic Information

## Please complete all information & questions: Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Street Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Home\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### City\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_Phone/Work\_\_\_\_\_\_\_\_\_\_\_\_\_Fax\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_ Age\_\_\_\_\_\_\_ Race\_\_\_\_\_\_ Weight (stripped)\_\_\_\_\_\_ Ht \_\_\_\_\_\_

Male(waist measurement)\_\_\_\_\_\_\_ Female(hip measurement)\_\_\_\_\_\_\_

Blood Pressure \_\_\_\_\_\_\_\_\_\_\_ Blood Type (A,B,AB,O)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-mail\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Referred by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Occupation: Current \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Past\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### **Please make a copy of all the information that you return to Lifestyle Fitness & Nutrition**

**So that you can follow along during your consultation**

**& have for your records.**

INSTRUCTIONS:

1. Complete the Individual Health Profile Questionnaire & Mail/Scan or Fax to:

Lifestyle Fitness & Nutrition 3708 Fairways Court, Fredericksburg, VA 22408

Fax: 540-891-4050

Do you consider your general health to be? Excellent Good Fair Poor

What is your outlook on life in general? Excellent Good Fair Poor

The health consult will address your total health picture; however, we would like to know your top 3 health concerns, symptoms and/or goals: *Attach another sheet if more space is needed.*

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you prefer **gradual** or **comprehensive** change changes to diet and lifestyle?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under a physician’s care? \_\_\_Yes \_\_\_No If yes, why?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**□ Yes □ No** Have you ever been hospitalized or had major surgery?

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_ Surgery \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you now or have you recently had an infection?

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Are you taking any medications, antibiotics, pills, or drugs? (include aspirin if you take it to prevent heart disease)

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose** | **Reason** | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_ | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

\*If more space is needed, add additional information to an attached sheet.

Do you have or have you had any of the following? (please explain “yes” answers on a separate sheet & enclose with this questionnaire)

|  |  |  |  |
| --- | --- | --- | --- |
| **Yes No** | **Yes No** | **Yes No** | **Yes No** |
| **□ □** Heart Disease/  Arteriosclerosis | **□ □** Cancer:  Type\_\_\_\_\_\_\_\_\_\_\_\_\_ | **□ □** Rheumatoid Arthritis | **□ □** Nervousness |
| **□ □** High/Low  Blood Pressure | **□ □** Radiation Treatments | **□ □** Osteoarthritis | **□ □** Hallucinations |
| **□ □** Chest Pain | **□ □** Chemotherapy  Treatment | **□ □** Joint Pain/Swelling | **□ □** Autism |
| **□ □** High Cholesterol | **□ □** Tumors/ Growths | **□ □** Bone Fractures | **□ □** Antidepressants |
| **□ □** High Triglyceride | **□ □** Stomach/  Intestinal Disorder | **□ □** Gout | **□ □** Psychiatric Care |
| **□ □** Blood Disease | **□ □** Bowel Disorder | **□ □** Cortisone/Steroids | **□ □** Suicidal |
| **□ □** Stroke | **□ □** Iron Overload  Hemochromatosis | **□ □** Ulcers | **□ □** Depression |
| **□ □** Bruise Easily | **□ □** Frequent Diarrhea | **□ □** Chronic Fatigue  Syndrome | **□ □** Sinus Headaches |
| **□ □** Varicose Veins | **□ □** Constipation | **□ □** Fibromyalgia | **□ □** Alzheimer’s Disease |
| **□ □** Anemia | **□ □** Anorexia | **□ □** Unexplained Fever | **□ □** Dementia |
| **□ □** Bleeding Disorders/  Hemophilia | **□ □** Bulimia | **□ □** Swollen  Glands/Nodes | **□ □** Difficulty  Concentrating |
| **□ □** Leukemia | **□ □** Diabetes:  Type\_\_\_\_\_\_\_\_\_\_\_\_ | **□ □** Venereal Disease | **□ □** Allergies (To-  Medicines)Type\_\_\_\_\_\_\_\_\_\_\_\_ |
| **□ □** Sickle Cell Disease | **□ □** Hypoglycemia | **□ □** AIDS | **□ □** Allergies (To Food) |
| **□ □** Osteoporosis | **□ □** Excessive Thirst | **□ □** HIV Positive | **□ □** Allergies  (To Pollen/Dust) |
| **□ □** Breathing Problem  Shortness of Breath | **□ □** Night Sweats | **□ □** Blood Transfusion | **□ □** Hives/Rashes |
| **□ □** Lung Disease | **□ □** Liver Disease | **□ □** Herpes | **□ □** Excessive  Perspiration |
| **□ □** Snoring | **□ □** Hepatitis | **□ □** Bleeding Gums | **□ □** Cold/Clammy Skin |
| **□ □** Frequent Cough | **□ □** Yellow Jaundice | **□ □** Periodontal (Gum)  Disease | **□ □** Speech Disorders |
| **□ □** Sinus Trouble | **□ □** Kidney Problems | **□ □** Cold Sores/  Fever Blisters | **□ □** Drug Addiction |
| **□ □** Asthma | **□ □** Renal Dialysis | **□ □** Mouth Ulcers | **□ □** ALS/  Lou Gehrig’s Disease |
| **□ □** Emphysema | **□ □** Gall Bladder  Disease/Stones | **□ □** Frequent Tooth  Decay | **□ □** Epilepsy/Seizures |
| **□ □** Tuberculosis | **□ □** Thyroid Disease | **□ □** Bad Breath  (Halitosis) | **□ □** Convulsions |
| **□ □** Hemorrhoids | **□ □** Parathyroid Disease | **□ □** Dentures | **□ □** Vision Problems |
| **□ □** Overweight | **□ □** Pregnant/Uncertain  (currently) | **□ □** Calculus (Tartar)  on Teeth | **□ □** Glaucoma |
| **□ □** Underweight | **□ □** Nursing | **□ □** Fainting/Dizziness | **□ □** Ear Problems |
| **□ □** Prostate Problems | **□ □** Numbness | **□ □** Sleep Disorders | **□ □** Chronic Migraines/or  Headaches |
|  |  |  |  |
|  |  |  |  |

**If any “blood” relatives (e.g., father, mother, grandparents, brothers, sisters, etc.) have had any of the health issues listed on the previous page, please explain.**

**Yes No**

**\_\_\_ \_\_\_ Father \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_ Mother \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_ Grandparents \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_ Siblings\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ \_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **DIET** |

**□ Yes □ No** Have you experienced any weight changes in the last 6 months?

**□ Gain \_\_\_lbs. □ Loss \_\_\_ lbs.**

**□ Yes □** No Are you currently on a diet or do you diet frequently? Please Explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you are dieting, does your diet have a name? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was it recommended by someone? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you maintain a healthy diet (i.e., protein, fresh fruits, grains, vegetables, & cultured dairy)?

Explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FOODS AND NUTRITION** |

**Please give an example of your typical breakfast, lunch, dinner & snacks.**

**□ Yes □ No** Breakfast? Sample of typical breakfast: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What time do you normally eat breakfast? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Lunch? Sample of typical lunch: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What time do you normally eat lunch? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Dinner? Sample of typical dinner: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What time do you normally eat dinner? \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Snack? Sample of typical snack: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

What time do normally snack? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you eat processed/refined carbohydrates (e.g., pasta, white bread, potatoes, snacks, desserts, sugar, candy, artificial sweeteners, MSG, etc.)? List which ones & how often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Which of the following foods do you prefer to eat the most?**

\_\_\_\_ Meat, eggs, beans \_\_\_\_ Vegetables \_\_\_\_ Dairy Products

**\_\_\_\_** Fruits \_\_\_\_ Breads, grains, cereals

**Which of the following foods would you most likely skip?**

\_\_\_\_ Meat, eggs, beans \_\_\_\_ Vegetables \_\_\_\_ Dairy Products

**\_\_\_\_** Fruits \_\_\_\_ Breads, grains, cereals

**Which of the following foods do you regularly eat and how often?**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOODS** | **SERVINGS** (How Often) | | **SERVINGS** (How Much) (Indicate portion size if you don’t know ounces) | | | |
| ***High Protein Foods*** | ***Per Day*** | ***Per Week*** | ***Ounces*** | ***Small*** | ***Medium*** | ***Large*** |
| Beef | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Pork | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Poultry | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Fish | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Cheese | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Eggs | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Nuts | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Whole grains | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Beans/Peas | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Tofu | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |
| Protein Powder | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_\_\_** |

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| --- |
| **FOODS AND NUTRITION** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOODS** | **SERVINGS** (How Often) | | **SERVINGS** (How Much) (Indicate portion size if you don’t know ounces) | | | |
| ***High Calcium Foods*** | ***Per Day*** | ***Per Week*** | ***Ounces*** | ***Small*** | ***Medium*** | ***Large*** |
| Sardines | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Salmon | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Milk | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Buttermilk | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Plain Yogurt | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Flavored Yogurt | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cottage Cheese | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cheeses (soft) |  |  |  |  |  |  |
| Cheeses (hard) | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOODS** | **SERVINGS** (How Often) | | **SERVINGS** (How Much) (Indicate portion size if you don’t know ounces) | | | |
| ***High Oxalate Foods*** | ***Per Day*** | ***Per Week*** | ***Ounces*** | ***Small*** | ***Medium*** | ***Large*** |
| Spinach | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Beet greens | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Rhubarb | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Swiss chard | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |  |  |  |
| ***High Purine Foods*** |  |  |  |  |  |  |
| Liver | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Kidney | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Sweetbreads | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Fish Roe | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |  |  |  |
| ***High Citrate Foods*** |  |  |  |  |  |  |
| Lemons (whole) | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Lemon juice | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Oranges (whole) | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Orange juice | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Grapefruit (whole) | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Grapefruit juice | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
|  |  |  |  |  |  |  |
| ***Carbohydrates*** |  |  |  |  |  |  |
| Potatoes | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Bread | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Rice | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Pasta | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cereals | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cake, Pies | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cookies | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Ice Cream | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |

List other simple carbohydrates that you eat and tell how often & how much: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **FOODS AND NUTRITION** |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **FOODS** | **SERVINGS** (How Often) | | **SERVINGS** (How Much) (Indicated portion size if you don’t know ounces) | | | |
| ***Fats*** | ***Per Day*** | ***Per Week*** | ***Ounces*** | ***Small*** | ***Medium*** | ***Large*** |
| Margarine | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Butter | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Yogurt Spread | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Vegetable Oil | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Olive Oil | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |
| Cream | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** | **\_\_\_\_\_\_\_\_\_** |

List other fats, how often & how much \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you have a problem with gas/belching? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do any foods cause you discomfort? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Are you allergic to any foods? Explain \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Supplements/Vitamins**

**□ Yes □ No** Do you take food supplements/vitamins on a regular basis?

If “Yes”, briefly describe the following:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Vitamin/Supplement** | **Dose** (per use) | **Total Dose** (per day) | **Brand Name** | **Reason** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please attach a copy of your current vitamin/supplement schedule if you desire to add additional information**

|  |
| --- |
| **LIFESTYLE INFORMATION** |

**Do you fall asleep easily & sleep soundly?** **□ Yes □ No**

What time do you go to bed ? \_\_\_\_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What time do you awake? \_\_\_\_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you take anything to help you sleep? Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you frequently wake in the night & have trouble getting back to sleep?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Lifestyle** |
| **Information** |

**Do you breathe air that is of good quality?**

**□ Yes □ No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you live in a healthy environment?** (please check one)

Home \_\_\_ Apartment \_\_\_ Mobile Home \_\_\_ Condo/Townhome \_\_\_ Other \_\_\_

**□ Yes □ No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you work in a healthy environment?**

**□ Yes □ No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Hobbies:** Please list your hobbies and indicate if you might be exposed to toxins (e.g., if you enjoy stained glass assembly, you may be exposed to solvents, lead fumes, etc.; if you enjoy painting, you may be exposed to solvents, petrochemicals, etc)

|  |  |
| --- | --- |
| **Hobby** | **Possible Exposure** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Are you now or were you ever exposed to substances that could endanger health?**

(e.g., lead mercury, chemicals, dusts, fumes, gases, etc.)

**□ Yes □ No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your source of drinking water?** Filtered **□** Municipal **□**

Bottled **□** Well **□**

**What is your daily water intake?**

**□** 2 glasses (16oz) **□** 8 glasses (64 oz) **□** Other

**□** 4 glasses (32 oz) **□** 10 glasses (80 oz)

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **What else do you drink?** | | **Day** | **Week** |  | **Day** | **Week** |  | **Day** | **Week** | **Other** |
| Enter amount Per day/week  in blocks | Soda/Pop | **□** | **□** | Tea (regular) | **□** | **□** | White Wine | **□** | **□** | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Orange Juice | **□** | **□** | Tea (herbal) | **□** | **□** | Beer | **□** | **□** | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Juice | **□** | **□** | Coffee(regular) | **□** | **□** | Hard Liquor | **□** | **□** | \_\_\_\_\_\_\_\_\_\_\_\_ |
| Milk | **□** | **□** | Coffee (decaf) | **□** | **□** | Other | **□** | **□** | \_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Soy Milk | **□** | **□** | Red Wine | **□** | **□** |  |  |  | \_\_\_\_\_\_\_\_\_\_\_\_ |

**Do you feel you have an alcohol problem?**

**□ Yes □ No** Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How many times do you urinate each day? \_\_\_\_\_\_\_\_**

**□ Yes □ No** Does it burn when you urinate?

**□ Yes □ No** Do you get up at night to urinate?

**□ Yes □ No** Do you have a urinary tract infection?

**How many bowel movements do you have per day? What color/consistency is your bowel movement?**

**□** 1 Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Brown/Tan **□** Soft

**□** 2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Green or Black **□** Medium

**□** 3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Yellow or Red **□** Hard

|  |
| --- |
| **DENTAL INFORMATION TO BE COMPLETED BY THE CLIENT** |

**□ Yes □ No** Do you presently have amalgam/silver fillings. If yes, how many? **\_\_\_\_\_\_**

**□ Yes □ No** Have you had amalgam/silver fillings replaced with tooth colored fillings?

If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_ When?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□Yes □ No** Do you have crowns and/or bridges? If yes, how many?\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you have any root canal treated teeth? If yes, how many? \_\_\_\_\_\_\_\_\_

**□ yes □ No** Have you had implants placed? If yes, how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Have you had oral surgery? (Extractions, TMJ, Periodontal)

If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Have you been diagnosed with gum/bone disease?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Are your teeth sensitive to hot, cold, sweet, or pressure? Explain

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ Yes □ No** Do you have a metallic taste in your mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Have you noticed a loss of taste and/or smell? Explain\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ Yes □ No** Are your mouth and/or lips cracked, dry or sore?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**□ Yes □ No** Do you wear any type of removable appliance? If yes, indicate type:

**□** Upper Denture **□** Lower Denture **□** Upper Partial Denture **□** Lower Partial Denture

**□** Splint **□** Night Guard **□** Other

**□ Yes □ No** Have you ever been diagnosed with a Cavitation? (A Cavitation refers to a toxin-containing hole in the jawbone at the site of a previously extracted tooth). If so, please explain\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **MORE GENERAL INFORMATION** |

Do you or have you ever smoked or used tobacco? **□ Yes □ No** If yes, how many years? \_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Tobacco Source** | **Frequency per day** |
| **□** Cigarettes | **\_\_\_\_\_\_\_\_\_\_** |
| **□** Cigars | **\_\_\_\_\_\_\_\_\_\_** |
| **□** Pipe | **\_\_\_\_\_\_\_\_\_\_** |
| **□** Chewing Tobacco | **\_\_\_\_\_\_\_\_\_\_** |
| **□** Second Hand Exposure | **\_\_\_\_\_\_\_\_\_\_** |

**Do you feel you have a drug habit? □ Yes □ No If yes, how many years? \_\_\_\_\_\_\_**

Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **EXERCISE INFORMATION** |

**Do you engage in exercise or regular physical activity** (totaling at least 20 minutes 5 days of the week)?

**□ Yes □ No**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Type*** | ***Duration/Workout*** | ***Times/Week*** |  |
| Aerobic | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_ |  |

Walking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Running \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hiking \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Bicycle \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Eliptical Trainer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Rowing \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Strength Training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pilates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yoga \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tai Chi \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CrossFit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Please mail/Fax/Scan the entire questionnaire to: Lifestyle Fitness & Nutrition3708 Fairways CourtFredericksburg, VA 22408 **540-898-5219**  **Fax: 540-891-4050**  **Signature: Date:** |

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| **Confidentiality Statement:** Lifestyle Fitness & Nutrition guarantees that information supplied by the client will not be given to any other individual, organization, doctor, healthcare facility, or insurance provider without the expressed written consent of the client. |