Nutrition and Integrative Health

Adult Questionnaire

Marble Arch Gardens
Holistic Herbals

Nutritional Wellness Assessment

Instructions for your first nutrition consultation

Thank you for filling out the questionnaire, please provide as much information as you can, this will enable a more complete review during our first visit.

Required for your first visit:

- The completed Adult Questionnaire, along with the 6-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 drinks, even water.
  - 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 drink 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 added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.

- Please bring any lab-work you may have available from your doctor

Please bring the following:

- If you are taking any pharmaceuticals, over-the-counter drugs, and/or supplements, please bring them in their original containers so the ingredients and amounts that are in the products can be identified.

Please call or email if you have any questions.

NUTRITION
Adult Questionnaire

Client confidentiality will be maintained always. 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 6-day diet diary will require you to record your food and drink intake over a 6-day period. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment and 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.

Primary Care Physician's Name:
Physician Address:

Physician Office Number:
Physician Fax Number:

Basic Information

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:	lb..	Highest Adult Weight:	lb.. / Yr.:			Lowest Adult Weight:	lb.. / 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?

How did you hear about Marble Arch Gardens Nutritional Wellness Center?

What are your primary reasons for coming to Marble Arch Nutritional Wellness?

1.
2.
3.

Medical Information

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

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?

Medications & Supplements

Past and Current Medications (Over-the-counter and Prescription)				
Name	Dosage	Frequency	Length of Time	Reason for Taking
Are you sensitive to low levels of medication(s) and/or caffeine?				

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

Review of Body Systems

Please place an **"X"** next to anything you are currently experiencing. Issues that you had previously, but no longer have, mark with a **"P."** Also provide answers to those items marked with a question mark.

Head
- seizure
- headache
- migraines

Eyes/Ears/Nose
- vision loss
- eye discharge
- eye redness
- ear/eye infection
- corrective lenses
- hearing loss
- ringing the ears
- ear discharge/itching
- pain
- nosebleed
- nasal congestion

Neck and Throat
- pain
- lump
- enlarged thyroid
- stiffness
- tonsillitis

Male Reproductive
- difficulty with urination
- Benign Prostatic Hypertrophy
- pain / swelling in testicles or prostate
- vasectomy
- erectile insufficiency
- low sperm count
- poor sperm motility

Lymph Nodes
- congestion
- swollen
- painful

Other

Female Reproductive

Breasts
- tenderness
- abnormalities, lumps
- discharge
- perform breast self-exams?

Genitals
- vaginal discharge
- yeast infections
- pelvic pain or masses
- abnormal pap, resulting action?

Menses

Date of last menses

Length of menses days
- painful cramps
- bleeding between cycles
- not menstruating
- fibroids
- endometriosis
- PCOS

Menopausal women
- menopausal symptoms
- vaginal dryness
- hormone replacement therapy
- osteoporosis

Male and Female

sexually transmitted disease?

Birth control, what form?
- low libido
- painful intercourse /orgasm

Neuropsychiatric
- phobias
- insomnia
- depression
- anxiety
- attention deficit
- mental sluggishness
- other mental disorder
- abnormal physical movements

Gastrointestinal
- bad breath
- ulcers
- bloating/gas
- pain/cramping
- nausea
- acid reflux/GERD
- constipation
- variable bowel habits
- diarrhea
- undigested food in stools
- blood in stools
- hemorrhoids
- liver/gallbladder issues

Bowel movements

per day? OR # per week?

Quality?
- pebbly
- fully formed
- soft & largely unformed
- loose and unformed

Respiratory
- congestion
- sinus pain/inflammation
- difficulty breathing
- cough
- asthma
- tuberculosis

Urinary

Urinations a day?

color of urine?
- urinary tract infection
- kidney infection
- kidney stones
- swelling
- incontinence
- urgency
- frequency
- pain on urination
- blood in urine
- dark circles under eyes

Cardiovascular
- heart attack
- low blood pressure
- high blood pressure
- heart palpitations
- chest pain
- high cholesterol
- varicose/spider veins
- cold hands and feet
- stroke
- clotting disorder
- bruise easily

Endocrine
- Low energy level
- Hypothyroid (low)
- Hyperthyroid (high)
- Low blood sugar
- Diabetes

Skin
- rash
- dry skin
- itching
- acne
- rosacea
- bruise easily
- nail problems
- hair quality changes
- slow wound healing

Musculoskeletal
- muscle pain
- arthritis / joint pain
- stiffness
- gout
- back ache/pain
- mobility restrictions

Allergic & Immunologic
- respiratory allergies
- immune disorder
- frequent colds or flu
- food allergies
- food sensitivities

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?
Are you aware that you should inform your practitioner if you decide to conceive or if you become pregnant?

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		

Lifestyle

PHYSICAL ACTIVITY					
Food/Drink	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, meditative activity					What type(s)?
How would you categorize your activity level?			Sedentary	Mildly Active	Moderately Active Very Active Intensely Active

Other:

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

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?	

NUTRITION					
Food/Drink	Frequency				Comments
	Monthly	Weekly	Daily	Multiple times a day	
Caffeine					In what form?
Soda/Soft Drinks					What type(s)?
Alcohol					What type(s)?
Herb tea					What type(s)?
Red Meat					Beef, Lamb, Sausage/deli
White Meat					Poultry, Pork 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)?

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
Where do you grocery shop?	

Nutrition Days 1-3 Food Diary Record information as soon as possible after the food has been consumed. Please include all drinks, even water.		
Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack

Dinner	Dinner	Dinner
Snack	Snack	Snack

Nutrition Days 4-6 Food Diary Record information as soon as possible after the food has been consumed. Please include all drinks, even water.		
Day 4	Day 5	Day 6
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack

Dinner	Dinner	Dinner
Snack	Snack	Snack

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

other:

Significant Life Events

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

Date Event

Thank you for taking the time to complete this questionnaire.