Listen Nutrition
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NUTRITION

Adult Questionnaire

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 nutritional assessment. 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

Occupation & Interests							
Occupation:		How long?		Satisfied? (1-10)			
What are your interests/passions:							
Demographics							
Age		Gender		Race		Ethnicity	
Height:		Weight	lbs.	Highest Adult Weight	lbs. / Yr.:	Lowest Adult Weight	lbs. / Yr.:
Waist		hips		BP		HR	
Relationship Information							
Status		Partner's Gender		Ethnicity:			
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?

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

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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:
O = 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
___ **Total**

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					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)?
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

Nutrition - 3-Day Food Diary Record information as soon as possible after the food has been consumed. Please include all beverages, 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

Thank you for taking the time to complete this questionnaire for your student's case study assignment.