NUTRITIONAL QUESTIONNAIRE

Name_____ Date _____
Address_____ Phone _____

What kind of degenerative diseases run in your family?
❑cancer ❑heart disease ❑diabetes ❑arthritis ❑other _____

Do you get sick often? ❑virus ❑flu ❑sore throat ❑colds ❑other _____

About how many colds do you have a year? ❑1-2 year ❑3-4 year ❑more

How's your digestion? ❑heart burn ❑belching ❑gas ❑constipation

Have you even taken antibiotics? ❑yes ❑no How often? _____

How are your vital statistics? cholesterol ❑high ❑normal ❑low
blood pressure ❑high ❑normal ❑low

Do you use any medication? ❑yes ❑no If yes, what kind _____

Are you tired much? ❑morning ❑evening ❑after meals ❑all the time

How's your energy? 1 2 3 4 5 6 7 8 9 10 (1 wiped out -10 dynamo)

Are you aware of the problems with the American diet? (high in fat, salt, sugar, processed foods, low in fiber, water, micronutrients, etc.) ❑yes ❑no

How well do you eat?	❑excellent	❑good	❑poor
Do you eat out much?	❑daily	❑weekly	❑monthly
Do you drink coffee?	❑yes	❑no	How much? _____
Do you smoke?	❑yes	❑no	How much? _____
Do you drink?	❑yes	❑no	How much? _____

What kind of exercise do you do? _____
How often? _____ How long? _____

What supplements are you taking now? _____
How long? _____ Have they helped? ❑yes ❑no

What would you like to improve or achieve in relation to your health?

_____

On a scale of 1 to 10, how committed are you to taking care of your health and well-being in the future? 1 2 3 4 5 6 7 8 9 10 (1 not very -10 extremely)