

NT1:1 - Nutritional Assessment Questionnaire

Name: _____

Date: ____/____/____

Birth Date: _____

Gender: _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

PART I Read the following questions and circle the number that applies:

KEY: **0 = Do not consume or use** **2 = Consume or use weekly**
 1 = Consume or use 2 to 3 times monthly **3 = Consume or use daily**

DIET

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|---|----------------------------------|---|
| 1. 0 1 2 3 Alcohol | 7. 0 1 2 3 Cigars/pipes | 14. 0 1 Radiation exposure (0=no, 1=yes) |
| 2. 0 1 2 3 Artificial sweeteners | 8. 0 1 2 3 Caffeinated beverages | 15. 0 1 2 3 Refined flour/baked goods |
| 3. 0 1 2 3 Candy, desserts, refined sugar | 9. 0 1 2 3 Fast foods | 16. 0 1 2 3 Vitamins and minerals |
| 4. 0 1 2 3 Carbonated beverages | 10. 0 1 2 3 Fried foods | 17. 0 1 2 3 Water, distilled |
| 5. 0 1 2 3 Chewing tobacco | 11. 0 1 2 3 Luncheon meats | 18. 0 1 2 3 Water, tap |
| 6. 0 1 2 3 Cigarettes | 12. 0 1 2 3 Margarine | 19. 0 1 2 3 Water, well |
| | 13. 0 1 2 3 Milk products | 20. 0 1 2 3 Diet often for weight control |

LIFESTYLE

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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|--|---|
| 25. 0 1 Antacids | 39. 0 1 Diuretics |
| 26. 0 1 Antianxiety medications | 40. 0 1 Estrogen or progesterone (pharmaceutical, prescription) |
| 27. 0 1 Antibiotics | 41. 0 1 Estrogen or progesterone (natural) |
| 28. 0 1 Anticonvulsants | 42. 0 1 Heart medications |
| 29. 0 1 Antidepressants | 43. 0 1 High blood pressure medications |
| 30. 0 1 Antifungals | 44. 0 1 Laxatives |
| 31. 0 1 Aspirin/Ibuprofen | 45. 0 1 Recreational drugs |
| 32. 0 1 Asthma inhalers | 46. 0 1 Relaxants/Sleeping pills |
| 33. 0 1 Beta blockers | 47. 0 1 Testosterone (natural or prescription) |
| 34. 0 1 Birth control pills/implant contraceptives | 48. 0 1 Thyroid medication |
| 35. 0 1 Chemotherapy | 49. 0 1 Acetaminophen (Tylenol) |
| 36. 0 1 Cholesterol lowering medications | 50. 0 1 Ulcer medications |
| 37. 0 1 Cortisone/steroids | 51. 0 1 Sildenafil citrate (Viagra) |
| 38. 0 1 Diabetic medications/insulin | |

PART II (See key at bottom of page)

Section 1

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|---|--|
| 52. 0 1 2 3 Belching or gas within one hour after eating | 61. 0 1 2 3 Feel like skipping breakfast |
| 53. 0 1 2 3 Heartburn or acid reflux | 62. 0 1 2 3 Feel better if you don't eat |
| 54. 0 1 2 3 Bloating within one hour after eating | 63. 0 1 2 3 Sleepy after meals |
| 55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes) | 64. 0 1 2 3 Fingernails chip, peel or break easily |
| 56. 0 1 2 3 Bad breath (halitosis) | 65. 0 1 2 3 Anemia unresponsive to iron |
| 57. 0 1 2 3 Loss of taste for meat | 66. 0 1 2 3 Stomach pains or cramps |
| 58. 0 1 2 3 Sweat has a strong odor | 67. 0 1 2 3 Diarrhea, chronic |
| 59. 0 1 2 3 Stomach upset by taking vitamins | 68. 0 1 2 3 Diarrhea shortly after meals |
| 60. 0 1 2 3 Sense of excess fullness after meals | 69. 0 1 2 3 Black or tarry colored stools |
| | 70. 0 1 2 3 Undigested food in stool |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 2

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|-----|---------|--|-----|---------|--|
| 71. | 0 1 2 3 | Pain between shoulder blades | 85. | 0 1 | Easily hung over if you were to drink wine (0=no, 1=yes) |
| 72. | 0 1 2 3 | Stomach upset by greasy foods | 86. | 0 1 2 3 | Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14) |
| 73. | 0 1 2 3 | Greasy or shiny stools | 87. | 0 1 | Recovering alcoholic (0=no, 1=yes) |
| 74. | 0 1 2 3 | Nausea | 88. | 0 1 | History of drug or alcohol abuse (0=no, 1=yes) |
| 75. | 0 1 2 3 | Sea, car, airplane or motion sickness | 89. | 0 1 | History of hepatitis (0=no, 1=yes) |
| 76. | 0 1 | History of morning sickness (0 = no, 1 = yes) | 90. | 0 1 | Long term use of prescription/recreational drugs (0=no, 1=yes) |
| 77. | 0 1 2 3 | Light or clay colored stools | 91. | 0 1 2 3 | Sensitive to chemicals (perfume, cleaning agents, etc.) |
| 78. | 0 1 2 3 | Dry skin, itchy feet or skin peels on feet | 92. | 0 1 2 3 | Sensitive to tobacco smoke |
| 79. | 0 1 2 3 | Headache over eyes | 93. | 0 1 2 3 | Exposure to diesel fumes |
| 80. | 0 1 2 3 | Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months) | 94. | 0 1 2 3 | Pain under right side of rib cage |
| 81. | 0 1 | Gallbladder removed (0=no, 1=yes) | 95. | 0 1 2 3 | Hemorrhoids or varicose veins |
| 82. | 0 1 2 3 | Bitter taste in mouth, especially after meals | 96. | 0 1 2 3 | Nutrasweet (aspartame) consumption |
| 83. | 0 1 | Become sick if you were to drink wine (0=no, 1=yes) | 97. | 0 1 2 3 | Sensitive to Nutrasweet (aspartame) |
| 84. | 0 1 | Easily intoxicated if you were to drink wine (0=no, 1=yes) | 98. | 0 1 2 3 | Chronic fatigue or Fibromyalgia |

Section 3

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|------|---------|--|------|---------|--|
| 99. | 0 1 2 3 | Food allergies | 108. | 0 1 2 3 | Crohn's disease (0 =no, 1=yes in the past, 2=current mild condition, 3=severe) |
| 100. | 0 1 2 3 | Abdominal bloating 1 to 2 hours after eating | 109. | 0 1 2 3 | Wheat or grain sensitivity |
| 101. | 0 1 | Specific foods make you tired or bloated (0=no, 1=yes) | 110. | 0 1 2 3 | Dairy sensitivity |
| 102. | 0 1 2 3 | Pulse speeds after eating | 111. | 0 1 | Are there foods you could not give up (0=no, 1=yes) |
| 103. | 0 1 2 3 | Airborne allergies | 112. | 0 1 2 3 | Asthma, sinus infections, stuffy nose |
| 104. | 0 1 2 3 | Experience hives | 113. | 0 1 2 3 | Bizarre vivid dreams, nightmares |
| 105. | 0 1 2 3 | Sinus congestion, "stuffy head" | 114. | 0 1 2 3 | Use over-the-counter pain medications |
| 106. | 0 1 2 3 | Crave bread or noodles | 115. | 0 1 2 3 | Feel spacey or unreal |
| 107. | 0 1 2 3 | Alternating constipation and diarrhea | | | |

Section 4

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|------|---------|---|------|---------|--|
| 116. | 0 1 2 3 | Anus itches | 126. | 0 1 2 3 | Stools have corners or edges, are flat or ribbon shaped |
| 117. | 0 1 2 3 | Coated tongue | 127. | 0 1 2 3 | Stools are not well formed (loose) |
| 118. | 0 1 2 3 | Feel worse in moldy or musty place | 128. | 0 1 2 3 | Irritable bowel or mucus colitis |
| 119. | 0 1 2 3 | Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months) | 129. | 0 1 2 3 | Blood in stool |
| 120. | 0 1 2 3 | Fungus or yeast infections | 130. | 0 1 2 3 | Mucus in stool |
| 121. | 0 1 2 3 | Ring worm, "jock itch", "athletes foot", nail fungus | 131. | 0 1 2 3 | Excessive foul smelling lower bowel gas |
| 122. | 0 1 2 3 | Yeast symptoms increase with sugar, starch or alcohol | 132. | 0 1 2 3 | Bad breath or strong body odors |
| 123. | 0 1 2 3 | Stools hard or difficult to pass | 133. | 0 1 2 3 | Painful to press along outer sides of thighs (Iliotibial Band) |
| 124. | 0 1 | History of parasites (0=no, 1=yes) | 134. | 0 1 2 3 | Cramping in lower abdominal region |
| 125. | 0 1 2 3 | Less than one bowel movement per day | 135. | 0 1 2 3 | Dark circles under eyes |

Section 5

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|------|---------|--|------|---------|-------------------------------------|
| 136. | 0 1 | History of carpal tunnel syndrome (0=no, 1=yes) | 150. | 0 1 | History of bone spurs (0=no, 1=yes) |
| 137. | 0 1 | History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes) | 151. | 0 1 2 3 | Morning stiffness |
| 138. | 0 1 | History of stress fracture (0=no, 1=yes) | 152. | 0 1 2 3 | Nausea with vomiting |
| 139. | 0 1 2 3 | Bone loss (reduced density on bone scan) | 153. | 0 1 2 3 | Crave chocolate |
| 140. | 0 1 | Are you shorter than you used to be? (0=no, 1=yes) | 154. | 0 1 2 3 | Feet have a strong odor |
| 141. | 0 1 2 3 | Calf, foot or toe cramps at rest | 155. | 0 1 2 3 | History of anemia |
| 142. | 0 1 2 3 | Cold sores, fever blisters or herpes lesions | 156. | 0 1 2 3 | Whites of eyes (sclera) blue tinted |
| 143. | 0 1 2 3 | Frequent fevers | 157. | 0 1 2 3 | Hoarseness |
| 144. | 0 1 2 3 | Frequent skin rashes and/or hives | 158. | 0 1 2 3 | Difficulty swallowing |
| 145. | 0 1 | Herniated disc (0=no, 1=yes) | 159. | 0 1 2 3 | Lump in throat |
| 146. | 0 1 2 3 | Excessively flexible joints, "double jointed" | 160. | 0 1 2 3 | Dry mouth, eyes and/or nose |
| 147. | 0 1 2 3 | Joints pop or click | 161. | 0 1 2 3 | Gag easily |
| 148. | 0 1 2 3 | Pain or swelling in joints | 162. | 0 1 2 3 | White spots on fingernails |
| 149. | 0 1 2 3 | Bursitis or tendonitis | 163. | 0 1 2 3 | Cuts heal slowly and/or scar easily |
| | | | 164. | 0 1 2 3 | Decreased sense of taste or smell |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)

Section 6

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|---------------------|--|---------------------|--|
| 165. 0 1 | Experience pain relief with aspirin (0=no, 1=yes) | 169. 0 1 2 3 | Headaches when out in the hot sun |
| 166. 0 1 2 3 | Crave fatty or greasy foods | 170. 0 1 2 3 | Sunburn easily or suffer sun poisoning |
| 167. 0 1 2 3 | Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently) | 171. 0 1 2 3 | Muscles easily fatigued |
| 168. 0 1 2 3 | Tension headaches at base of skull | 172. 0 1 2 3 | Dry flaky skin or dandruff |

Section 7

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|---------------------|--|---------------------|--|
| 173. 0 1 2 3 | Awaken a few hours after falling asleep, hard to get back to sleep | 180. 0 1 2 3 | Headache if meals are skipped or delayed |
| 174. 0 1 2 3 | Crave sweets | 181. 0 1 2 3 | Irritable before meals |
| 175. 0 1 2 3 | Binge or uncontrolled eating | 182. 0 1 2 3 | Shaky if meals delayed |
| 176. 0 1 2 3 | Excessive appetite | 183. 0 1 2 3 | Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4) |
| 177. 0 1 2 3 | Crave coffee or sugar in the afternoon | 184. 0 1 2 3 | Frequent thirst |
| 178. 0 1 2 3 | Sleepy in afternoon | 185. 0 1 2 3 | Frequent urination |
| 179. 0 1 2 3 | Fatigue that is relieved by eating | | |

Section 8

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|---------------------|---|---------------------|--|
| 186. 0 1 2 3 | Muscles become easily fatigued | 200. 0 1 2 3 | Can hear heart beat on pillow at night |
| 187. 0 1 2 3 | Feel exhausted or sore after moderate exercise | 201. 0 1 2 3 | Whole body or limb jerk as falling asleep |
| 188. 0 1 2 3 | Vulnerable to insect bites | 202. 0 1 2 3 | Night sweats |
| 189. 0 1 2 3 | Loss of muscle tone, heaviness in arms/legs | 203. 0 1 2 3 | Restless leg syndrome |
| 190. 0 1 2 3 | Enlarged heart or congestive heart failure | 204. 0 1 2 3 | Cracks at corner of mouth (Cheilosis) |
| 191. 0 1 2 3 | Pulse below 65 per minute (0=no, 1=yes) | 205. 0 1 2 3 | Fragile skin, easily chaffed, as in shaving |
| 192. 0 1 2 3 | ringing in the ears (Tinnitus) | 206. 0 1 2 3 | Polyps or warts |
| 193. 0 1 2 3 | Numbness, tingling or itching in hands and feet | 207. 0 1 2 3 | MSG sensitivity |
| 194. 0 1 2 3 | Depressed | 208. 0 1 2 3 | Wake up without remembering dreams |
| 195. 0 1 2 3 | Fear of impending doom | 209. 0 1 2 3 | Small bumps on back of arms |
| 196. 0 1 2 3 | Worrier, apprehensive, anxious | 210. 0 1 2 3 | Strong light at night irritates eyes |
| 197. 0 1 2 3 | Nervous or agitated | 211. 0 1 2 3 | Nose bleeds and/or tend to bruise easily |
| 198. 0 1 2 3 | Feelings of insecurity | 212. 0 1 2 3 | Bleeding gums especially when brushing teeth |
| 199. 0 1 2 3 | Heart races | | |

Section 9

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|---------------------|--|---------------------|--|
| 213. 0 1 2 3 | Tend to be a "night person" | 226. 0 1 2 3 | Arthritic tendencies |
| 214. 0 1 2 3 | Difficulty falling asleep | 227. 0 1 2 3 | Crave salty foods |
| 215. 0 1 2 3 | Slow starter in the morning | 228. 0 1 2 3 | Salt foods before tasting |
| 216. 0 1 2 3 | Tend to be keyed up, trouble calming down | 229. 0 1 2 3 | Perspire easily |
| 217. 0 1 2 3 | Blood pressure above 120/80 | 230. 0 1 2 3 | Chronic fatigue, or get drowsy often |
| 218. 0 1 2 3 | Headache after exercising | 231. 0 1 2 3 | Afternoon yawning |
| 219. 0 1 2 3 | Feeling wired or jittery after drinking coffee | 232. 0 1 2 3 | Afternoon headache |
| 220. 0 1 2 3 | Clench or grind teeth | 233. 0 1 2 3 | Asthma, wheezing or difficulty breathing |
| 221. 0 1 2 3 | Calm on the outside, troubled on the inside | 234. 0 1 2 3 | Pain on the medial or inner side of the knee |
| 222. 0 1 2 3 | Chronic low back pain, worse with fatigue | 235. 0 1 2 3 | Tendency to sprain ankles or "shin splints" |
| 223. 0 1 2 3 | Become dizzy when standing up suddenly | 236. 0 1 2 3 | Tendency to need sunglasses |
| 224. 0 1 2 3 | Difficulty maintaining manipulative correction | 237. 0 1 2 3 | Allergies and/or hives |
| 225. 0 1 2 3 | Pain after manipulative correction | 238. 0 1 2 3 | Weakness, dizziness |

Section 10

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|---------------------|---|---------------------|---|
| 239. 0 1 | Height over 6' 6" (0=no, 1=yes) | 245. 0 1 | Height under 4' 10" (0=no, 1=yes) |
| 240. 0 1 | Early sexual development (before age 10) (0=no, 1=yes) | 246. 0 1 2 3 | Decreased libido |
| 241. 0 1 2 3 | Increased libido | 247. 0 1 2 3 | Excessive thirst |
| 242. 0 1 2 3 | Splitting type headache | 248. 0 1 2 3 | Weight gain around hips or waist |
| 243. 0 1 2 3 | Memory failing | 249. 0 1 2 3 | Menstrual disorders |
| 244. 0 1 | Tolerate sugar, feel fine when eating sugar (0=no, 1=yes) | 250. 0 1 | Delayed sexual development (after age 13) (0=no, 1=yes) |
| | | 251. 0 1 2 3 | Tendency to ulcers or colitis |

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
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Section 11

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252. 0 1 2 3 Sensitive/allergic to iodine	260. 0 1 2 3 Mentally sluggish, reduced initiative
253. 0 1 2 3 Difficulty gaining weight, even with large appetite	261. 0 1 2 3 Easily fatigued, sleepy during the day
254. 0 1 2 3 Nervous, emotional, can't work under pressure	262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
255. 0 1 2 3 Inward trembling	263. 0 1 2 3 Constipation, chronic
256. 0 1 2 3 Flush easily	264. 0 1 2 3 Excessive hair loss and/or coarse hair
257. 0 1 2 3 Fast pulse at rest	265. 0 1 2 3 Morning headaches, wear off during the day
258. 0 1 2 3 Intolerance to high temperatures	266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
259. 0 1 2 3 Difficulty losing weight	267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

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268. 0 1 2 3 Prostate problems	272. 0 1 2 3 Waking to urinate at night
269. 0 1 2 3 Difficulty with urination, dribbling	273. 0 1 2 3 Interruption of stream during urination
270. 0 1 2 3 Difficult to start and stop urine stream	274. 0 1 2 3 Pain on inside of legs or heels
271. 0 1 2 3 Pain or burning with urination	275. 0 1 2 3 Feeling of incomplete bowel evacuation
	276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

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277. 0 1 2 3 Depression during periods	287. 0 1 2 3 Breast fibroids, benign masses
278. 0 1 2 3 Mood swings associated with periods (PMS)	288. 0 1 2 3 Painful intercourse (dysparenia)
279. 0 1 2 3 Crave chocolate around periods	289. 0 1 2 3 Vaginal discharge
280. 0 1 2 3 Breast tenderness associated with cycle	290. 0 1 2 3 Vaginal dryness
281. 0 1 2 3 Excessive menstrual flow	291. 0 1 2 3 Vaginal itchiness
282. 0 1 2 3 Scanty blood flow during periods	292. 0 1 2 3 Gain weight around hips, thighs and buttocks
283. 0 1 2 3 Occasional skipped periods	293. 0 1 2 3 Excess facial or body hair
284. 0 1 2 3 Variations in menstrual cycles	294. 0 1 2 3 Hot flashes
285. 0 1 2 3 Endometriosis	295. 0 1 2 3 Night sweats (in menopausal females)
286. 0 1 2 3 Uterine fibroids	296. 0 1 2 3 Thinning skin

Section 14

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297. 0 1 2 3 Aware of heavy and/or irregular breathing	302. 0 1 2 3 Ankles swell, especially at end of day
298. 0 1 2 3 Discomfort at high altitudes	303. 0 1 2 3 Cough at night
299. 0 1 2 3 "Air hunger" or sigh frequently	304. 0 1 2 3 Blush or face turns red for no reason
300. 0 1 2 3 Compelled to open windows in a closed room	305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
301. 0 1 2 3 Shortness of breath with moderate exertion	306. 0 1 2 3 Muscle cramps with exertion

Section 15

13

307. 0 1 2 3 Pain in mid-back region	310. 0 1 2 3 Cloudy, bloody or darkened urine
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes	311. 0 1 2 3 Urine has a strong odor
309. 0 1 History of kidney stones (0=no, 1=yes)	

Section 16

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312. 0 1 2 3 Runny or drippy nose	317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
313. 0 1 2 3 Catch colds at the beginning of winter	318. 0 1 2 3 Acne (adult)
314. 0 1 2 3 Mucus producing cough	319. 0 1 2 3 Itchy skin (Dermatitis)
315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)	320. 0 1 2 3 Cysts, boils, rashes
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)	321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

Please complete and return to Nutritional Therapy 1:1 *prior to appointment*

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9520 SW Beaverton Hillsdale Hwy, Beaverton OR 97005

KEY: 0=No, symptom does not occur	2=Moderate symptom, occurs occasionally (weekly)
1=Yes, minor or mild symptom, rarely occurs (monthly)	3=Severe symptom, occurs frequently (daily)