NUTRITIONAL & HEALTH HISTORY QUESTIONNAIRE

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Name _____ Date: _____

Address _____City _____ State_____ Zip_____

Profession_____ e-mail address_____

Phone (work) _____ (home) _____ (cell) _____ Birth/Date _____

All information that you volunteer will remain confidential. If any question offends you or you feel it is an invasion of your privacy, just leave it blank.

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What is your main reason/your goal for making this appointment with Helen Cox?

Briefly list your health problems:

	Problem	Date Symptoms Began
1.		
2.		
3.		
4.		

What lifestyle changes do you know you need to make; such as dietary, exercise, relaxation, taking supplements.

	Changes	Rate how willing are you to make these changes [0-5] with 0 = not willing
1.		
2.		
3.		
4.		

How would you evaluate your general sense of well-being/your health? Make a mark on the line, then explain.

Premature Death _____ Optimal Health

How would you evaluate your stamina or general energy level?

Total Fatigue_____ Optimal Energy

Does it vary with the time of day: Yes___ No___ Please explain:

Does your energy level have any relationship to eating? Yes___ No___ Please explain:

Do you smoke? How much?

What percentage of your daily food intake is uncooked or raw?

How many glasses of water or other fluid do you drink daily? If other than water, what kind of fluid?

Please write down two samples of your daily meals that is typical for every day or nearly every day. Include desserts and what you drink with meals.

Time:		
	Breakfast:	Breakfast:
Time:	Lunch:	Lunch:
Time:	Dinner:	Dinner:

What do you usually snack on every day between meals?

Do you drink milk and/or eat cheese and other dairy products daily?

How often do you eat fried food?

Which of the following do you eat?

	How often?	How much?
Pastries		
Cakes		
Ice cream		
Candy		
Soft drinks		
Sugar in coffee or tea		
Pie		
Sweet rolls		
Cookies		

How much alcohol do you consume per day? Per week?

How much coffee do you drink per day? Per week?

What kind of cooking or salad oil do you use?

Do you use margarine?	Yes	No	What kind?
Do you eat butter?	Yes	No	How much daily?
Do you eat grains?	Yes	No	How much daily?
Do you use table salt?	Yes	No	How much?

How is your appetite?

Who does the shopping in your family?

Who does the food preparation for your family?

How many other [not including yourself] family members are in your home?

What dietary changes do you know you need to make?

How do you feel about making any dietary changes in your nutrition?

How will other family members respond to any dietary changes you may make in the future?

How often do you have a bowel movement? Do you need to strain to have a bowel movement?

Is your elimination bulky and soft? Or loose? Are the feces small, hard pieces?

Do you have hemorrhoids or any other rectal or bowel problems?

List any drugs or medications you presently take or have taken recently. Include prescription and nonprescription products such as diet pills and birth control pills, aspirin, laxatives, sleeping pills, etc.

How do you feel about taking food supplements?

Have you listened to the CD that is in the folder, "Welcome to Options Health Center"?
Yes No Will do before appointment

Have you watched the DVD that is in the folder, "Why You Need Whole Food Supplements?"
Yes No Will do before appointment

Are you willing to take up to five supplements per day?

List any vitamins or food supplements you are presently taking. Please bring them to your next appointment for Helen to review.

List any allergies:

Headaches worse in morning, wear off as day progresses. Y/N

Depression Y/N

Dry itchy skin, or brittle hair Y/N

Sensitive to cold weather Y/N

Wounds heal slowly Y/N

Catch colds easily Y/N

Poor circulation, i.e. cold, numb hands and feet Y/N

Stiffness in joints Y/N

Eat less than 5 vegetables and fruits per day Y/N

Weight gain Y/N

FEMALES ONLY

How regular are your menstrual periods?

Are they painful? If so, please describe:

How many pregnancies have you had?

MALES & FEMALES

List all surgeries and hospitalizations:

Describe any past illnesses or problems not listed above. Include injuries and falls, especially head, neck or back injuries:

Are there any significant health problems in your family? (Include grandparents, aunts and uncles.) List briefly:

What is your weight?

How much sleep do you normally get? Is it restful?

How much time do you spend indoors every day? Outdoors?

How much physical exercise daily or weekly? What kind?

How do you relax? How often?

How do you feel about your home and living situation?

How do you feel about your working situation?

What do you love to do?

How often do you do these things?

Please add any other information about yourself you feel might add to this evaluation:

Would you want any reading material on the following:

_____ Fatty Acids _____ Homocysteine _____Lipoprotein _____ Venous

Would you want any reading material on the following functional tests:

_____ Adrenal Stress _____Bone Health Panel _____ Female Hormones _____Gastro Intestinal

_____Male Hormones _____Post Menopausal Panel _____LPP [shows Cardiometabolic Risks]

_____AMAS [shows number of cancer cells in body]