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?

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?

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

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	**First Typical meal**	Time	**Second Typical meal**
	Breakfast:		Breakfast:
	Lunch:		Lunch:
	Dinner:		Dinner:

Which of the following do you eat?

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

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?

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?

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:

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:

List all surgeries and hospitalizations:

What is your weight?

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?

Yes	No		Yes	No	
		Depression			Catch colds easily
		Sensitive to cold weather			Stiffness in joints
		Dry itchy skin, or brittle hair			Eat less than 5 vegetables and fruits per day
		Wounds heal slowly			Weight gain
		Headaches in AM, then subside			Restful sleep. How much sleep do you get?_____

FEMALES ONLY

How regular are your menstrual periods? How many pregnancies have you had?

Are they painful? If so, please describe:

Yes	No	
		Directions: Circle the following ones that fit you: Stressed Wired and tired On the go Hyper Not back to normal after a stressor
		I have a virus.
		I have allergies and respiratory disorders.
		I am **under** 50 and I need liver support and am too stressed
		I am **over** 50, have normal blood pressure, and work **long hours or late nights**.
		I need to reduce and relax and not be a superman/super woman.
		I am stressed and wired in **morning only**
		Directions: Circle the following ones that fit you: Stressed & Tired Frazzled Crave Sugar Irritable Fatigue Weight Gain Low Libido Frequent Yawning Minor Low Back Pain Muscle Tension Poor Digestion Low Basal Temperature Use Caffeine, Salt, Or Alcohol To Give Me Energy
		I have allergies and respiratory disorders.
		I have allergies and respiratory disorders and **"burn out" respiratory** weakness.
		I am **under** 50 and I need liver support and am too stressed
		I am **over** 50, have normal blood pressure, and **work long hours or late nights**.
		• I have normal blood pressure. • I have an **energy slump between 2-4 pm**. • I am Type A personality and am wound up yet run down
		I have an **autoimmune** disease. I have normal or low blood pressure. I am fatigued.
		Energy starts out good, then **bottoms out about 10:00-12:00 AM**.
		I have normal blood pressure and eat meat.
		I have normal blood pressure and am a vegetarian.
		Directions: Circle the following ones that fit you: Down and Out Fatigue Malaise Low mood Difficulty sleeping Memory challenges Cognitive challenges
		I am COMPLETELY exhausted.
		I am **under** 50 and I need liver support and am too stressed
		I am **over** 50, have normal blood pressure, and work **long hours or late nights**.
		• I have normal blood pressure. • I have an **energy slump between 2-4 pm**. • I am Type A personality and am wound up yet run down
		I have an **autoimmune** disease. I have normal or low blood pressure. I am fatigued.
		I have normal blood pressure and eat meat.
		I have normal blood pressure and am a vegetarian.
		I have mood swings and sleeplessness/insomnia
		I need help getting to sleep and have sound sleep
		• Recovering from chronic infections and illnesses • Post-viral syndromes, surgery, trauma, antibiotic therapy • Radiation and chemotherapy support • Night sweats due to debility • Athletes with immune suppression from overtraining • I am debilitated, feel really defeated, hurt everywhere, and stress everywhere.
		I am completely worn out. I get up tired. I do not have any energy anytime of the day.

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 _____CMR [shows Cardiometabolic and Diabetic Risks]

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