NUTRITIONAL STATUS & LIFESTYLE QUESTIONNAIRE

A Guide for Personal Assessment

RenaiSante Institute of Integrative Medicine

Patient Information

Name: _____

Age: _____ Gender: M / F Date of Birth: _____

Address: _____

Telephone: _____ Email: _____

Please answer the following questions to help us assess your nutrition and wellness status.

A. PAR-Q

I.	Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor?	Yes	No
2.	Do you feel pain in your chest when you do physical activity?	Yes	No
3.	In the past month, have you had chest pain when you were not doing physical activity?	Yes	No
4.	Do you lose your balance because of dizziness or do you ever lose consciousness?	Yes	No
5.	Do you have a bone or joint problem that is aggravated by exercise (for example, back, knee, or hip) that could be made worse by a change in physical activity?	Yes	No
6.	Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart conditions?	Yes	No
7.	Do you know of any other reason why you should not do physical activity?	Yes	No

If you answered yes to number 7, please specify:

_____

B. Health History – Do you have a history of any of the following?

Heart disease	Yes	No
Heart attack	Yes	No
Stroke	Yes	No
Elevated cholesterol	Yes	No
Elevated triglycerides	Yes	No
Any other vascular condition	Yes	No
Do you have a history of Cancer? If so, which type:_____	Yes	No

Do you have a history of gastro-intestinal tract problems? (i.e.. gastritis. irritable bowel syndrome, stomach ulcers, food allergies or intolerances, colitis, Crohn's disease, etc.)

If yes please describe, including type of treatment rendered:

_____
_____
_____
_____

C. For Women Only

Are you pregnant?	Yes	No
Are you breast-feeding?	Yes	No
Do you have osteoporosis?	Yes	No
Do you have fibrocystic breast disease?	Yes	No
Have you had a bone mineral density evaluation (if over 50 years old)? If yes, when? (approximately): _____	Yes	No

D. Lifestyle Factors (non-diet related)

Are you a smoker? Yes No
If so, how many per day, and, for how many years?: ____/day for ____ years

Do you currently exercise on a regular basis? Yes No
If so, describe your regular exercise routine (type of exercise, how long, times per week etc.):

_____
_____
_____

E. Family History

Have either of your parents, or any of your siblings been diagnosed with, or died of, any of the following cancers? (check mark in the box indicates yes, please check all that apply)

- ❑ colon or rectal
- ❑ stomach
- ❑ lung
- ❑ breast
- ❑ pancreas
- ❑ cervical
- ❑ ovarian
- ❑ endometrial
- ❑ other: _____
- ❑ prostate
- ❑ throat
- ❑ mouth
- ❑ liver
- ❑ kidney
- ❑ bladder
- ❑ brain or spinal cord

Have any of your parents or siblings died of heart disease, heart attack or stroke before age 60?	Yes	No
Have any of your parents developed Diabetes Mellitus before age 60?	Yes	No
Do you have any other significant diseases, not previously mentioned, that occur commonly in your family?	Yes	No

If so, please list: _____

F. Systems Review and General Health

Have you ever had any of the following conditions? (check mark in the box indicates yes, please check all that apply)

- ❑ diabetes
- ❑ overactive thyroid gland
- ❑ underactive thyroid gland
- ❑ kidney disease
- ❑ liver disease
- ❑ Cushing's syndrome
- ❑ pancreatic disease
- ❑ lung disease (ex. emphysema)
- ❑ asthma
- ❑ other: _____
- ❑ epilepsy
- ❑ arthritis
- ❑ osteoporosis
- ❑ gall bladder disease
- ❑ prostatitis
- ❑ gout
- ❑ multiple sclerosis (MS)
- ❑ Parkinson's disease
- ❑ dementia

What level of stress do you routinely deal with? (0 = no stress, 10 = maximum stress)

0 1 2 3 4 5 6 7 8 9 10

What nutritional supplements do you take? (please include all vitamins, herbs, nutritional supplements [Greens +, protein powder etc.]):

_____
_____
_____
_____
_____
_____

List any allergies you have (seasonal, food, or otherwise):

_____
_____
_____

List any medications you are currently taking:

_____
_____
_____

List any surgeries you have had and the year they were performed:

_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

List any conditions, disabilities, or other health concerns not previously mentioned on this questionnaire:

_____
_____
_____
_____
_____

G. Wellness Goals

Indicate which health and fitness goals interest you:

- ❑ weight management
- ❑ improved fitness
- ❑ increased strength and muscle mass
- ❑ advice on proper, balanced nutrition
- ❑ advice on disease prevention
- ❑ anti-aging strategies
- ❑ rehabilitation of a muscle or joint injury
- ❑ supplementation advice based on my specific needs
- ❑ other: _____

Dietary Information

1) How often, on average, do you eat any of the following foods (*circle the appropriate letter below*):

- ground beef
- bacon
- pork products
- burgers
- spare ribs
- chicken wings
- processed luncheon meats (ex. bologna, salami)

a) daily
b) once per week
c) 1-2 times per week
d) 2-3 times per month
e) less than 2 times per month
f) never or once per month

2) How often, on average, do you consume any of the following foods:

- cheeses that are more than 20% milk fat (ex., cheddar cheese, mozzarella, Monterey Jack, brick, cream cheese, parmesan)
- homogenized milk
- yogurt that is more than 1% milk fat
- ice cream

a) daily
b) 3-6 times per week
c) 1-2 times per week
d) 2 times per month
e) less than 2 times per month
f) never or once per month

3) Do you use cream in your coffee or tea? If yes, how many cups per day do you average?___

Yes No

4) Do you routinely use butter on bread products such as bagels, toast, crackers, etc.?

Yes No Infrequently

5) Do you routinely use butter for cooking or on baked potatoes or other vegetables?

Yes No Infrequently

6) Do you use regular sour cream or high fat salad dressings (ex. French, Thousand Islands, Blue Cheese) more than once per week?

Yes No

7) What is your weekly whole egg consumption on average?

a) 12 or more eggs per week
b) 8-11 eggs per week
c) 5-7 eggs per week
d) 2-4 eggs per week
e) less than 2 eggs per week

8) How often do you eat fried foods?

a) 7 or more times per week
b) 5-6 times per week
c) 2-4 times per week
d) 0-1 times per week

9) Do you choose poultry or fish in place of red meat, pork or fried foods in most situations?

Yes No

10) Are you a vegetarian or near vegetarian? If yes. please describe (that is, are you vegan, lacto-ovo etc.?):_____

Yes No

11) How often, on average, do you consume any of the following:
- 2% milk
- low fat sour cream
- yogurt that is 2% milk fat
- margarine

a) 7 or more times per week
b) 4-6 times per week
c) 2-3 times per week
d) 0-1 times per week

12) How often, on average, do you consume any of the following foods?
- pastries such as cakes, croissants, turnovers
- premium ice cream
- donuts
- cookies (3 or more)
- high fat muffins
- rich desserts (ex. cheesecake, brownies)

a) 7 or more times per week
b) 4-6 times per week
c) 2-3 times per week
d) 0-1 times per week

13) How often, on average, do you consume any of the following snack foods?
- potato chips
- nachos
- any type of fried snack
- cheesies
- chocolate bars

a) 7 or more times per week
b) 4-6 times per week
c) 2-3 times per week
d) 0-1 times per week

14) How often, on average, do you consume any of the following snacks or drinks?
- regular soft drinks
- hard candy
- jujubes
- gummi bears or anything similar
- licorice

a) 7 or more times per week
b) 4-6 times per week
c) 2-3 times per week
d) 0-1 times per week

15) On average, how many servings per day do you consume of garden type vegetables (ex. carrots, tomatoes, broccoli, cauliflower, peppers, romaine lettuce, spinach, collard greens, kale)?

NOTE: each of the following is equal to one serving:
- ½ cup of most vegetables
- 1 tomato
- 1 large stalk of broccoli
- 8 oz. of food cooked in tomato sauce
- 1 large cauliflower floret
- 1 small garden salad
- 8 oz. of vegetable juice
- 8 oz. of vegetable soup

a) 5 or more servings per day
b) 3-4 servings per day
c) 1-2 servings per day
d) 0 servings per day

16) On average, how many servings per day do you consume of any of the following: pasta, rice, beans, peas, corn, barley, oatmeal?

NOTE: each of the following is equal to one serving:
- ½ cup of pasta, rice, beans, peas, corn, oatmeal, etc. (before cooking)
- 1 slice of bread
- ½ bagel
- ½ English muffin
- ¼ cup of most fibre cereals
- low-fat, high-fibre muffin

a) 5 or more servings per day
b) 3-4 servings per day
c) 1-2 servings per day
d) 0 servings per day

17) On average, how many servings of fruit do you have per day? Note: 1 serving = 1 whole fruit (e.g., apple, orange, peach) = *Vi* cup chopped fruit (i.e., fruit salad) = 8 oz. fruit juice

NOTE: each of the following is equal to one serving:
- 1 whole fruit (ex. apple, orange, peach)
- ½ cup of chopped fruit (i.e. fruit salad)
- 8 oz. fruit juice

a) 5 or more servings per day
b) 3-4 servings per day
c) 1-2 servings per day
d) 0 servings per day

18) What is your average alcohol consumption? (Note: 1 drink = 1 beer = 5 oz. glass of wine = 1 cocktail)

a) 3 or more drinks per day
b) 1-2 drinks per day
c) 2-3 drinks per week
d) 2-3 drinks per month
e) none

19) How often, on average, do you consume any food or drinks that are highly processed and contain preservative, artificial flavours, colours, and related chemicals?

NOTE: these foods would primarily include:
- diet and regular soft drinks, sugary fruit drinks
- potato chips, nachos, cheesies, corn chips etc.
- licorice, jujubes, gummy bears, gelatins etc.
- ice cream, fruit ices, sherbet etc.

a) 3 or more per day
b) 1-2 per day
c) 2-3 per week
d) once per week or less

20) Please complete the following section regarding vitamin/mineral supplementation:

Do you take a multivitamin and mineral supplement daily? Yes No

If yes, are your supplemental levels of (consult bottle label for this section):

Beta-carotene equal to or greater than 10 000 IU? Yes No

Vitamin E equal to or greater than 100 IU? Yes No

Vitamin C equal to or greater than 250 mg? Yes No

Vitamin and Mineral Supplementation Assessment

A. Dietary Habits

1.	Do you have fewer than 5 servings of fruits and vegetables per day on average?	Yes	No
2.	Do you consume citrus fruits fewer than 4 times per week on average?	Yes	No
3.	Do you consume 1 serving of orange-yellow fruits and vegetables fewer than 5 times per week on average? For example: ▪ 1 whole carrot ▪ 8 large apricots halves ▪ ¼ of a cantaloupe ▪ ½ cup melon squash ▪ 1 baked sweet potato ▪ 1 whole peach/nectarine	Yes	No
4.	Do you consume cruciferous vegetables (cabbage, cauliflower, broccoli, brussel sprouts) fewer than 5 times per week on average?	Yes	No
5.	Do you eat smoked meats or fish more than once per week on average?	Yes	No
6.	Do you eat luncheon meats, processed meats, sausages, bacon, bologna or any other nitrate salt containing meat once per week or more on average?	Yes	No
7.	Do you eat barbecued foods that are charred, once per week or more on average?	Yes	No
8.	Do you drink 3 or more cups of coffee per day on average?	Yes	No
9.	Do you consume less than two dairy servings per day on average? 1 serving = 8 oz. of milk or yogurt (preferably low-fat varieties) = 3-4 oz. of cheese (preferably low-fat varieties)	Yes	No
10.	Are you currently on a diet to lose weight or on a calorie-restricted program?	Yes	No
11.	Do you consume meat, poultry or fish less than four times per week?	Yes	No

B. Environmental Exposures

1.	Are you often exposed to second-hand smoke?	Yes	No
2.	Are you a smoker, or do you chew or snuff tobacco?	Yes	No
3.	Do you consume more than 4 alcoholic drinks per week on average? 1 drink = 1 beer (12 oz.) = 5 oz. glass of wine = 1 oz. of liquor	Yes	No
4.	Do you perform aerobic exercise on a regular basis? (more than 2x per week)	Yes	No
5.	Do you feel that stress is a big factor in your life?	Yes	No
6.	Do you live or work in an urban city where there are pollutants in smog or are you exposed to known industrial or environmental pollutants or toxins?	Yes	No
7.	Is your home or workplace adjacent to high voltage wires or high tension wires from overhead power lines?	Yes	No
8.	Do you work at or frequently use a computer video display monitor?	Yes	No
9.	Do you commonly drink tap water or use it to prepare meals instead of bottled water that has undergone reverse osmosis, distillation, or a combination of reverse osmosis and de-ionization?	Yes	No

C. Clinical Signs of Potential Nutrient Deficiencies

1.	Are you known to be Hypoglycemic (low blood sugar)?	Yes	No
2.	Do you get frequent colds, upper respiratory tract infections or urinary tract infections?	Yes	No
3.	For Women Only: Do you suffer from fibrocystic disease of the breast?	Yes	No
4.	For Women Only: Do you suffer excessively from premenstrual symptoms?	Yes	No
5.	Do you often experience cracks at the margins of your lips?	Yes	No
6.	Do you often experience a scaly, flaky seborrheic condition at the outer nose margins above the lips?	Yes	No
7.	Do you often experience a sore or burning tongue?	Yes	No
8.	Have you experienced a decreased ability to taste food?	Yes	No
9.	Do your gums often bleed easily?	Yes	No
10.	Have you noticed small red spots under your skin?	Yes	No
11.	Do you bruise easily?	Yes	No
12.	Are you a slow healer from cuts and wounds?	Yes	No
13.	Do you have soft nails?	Yes	No
14.	Are there white spots on or under your fingernails?	Yes	No
15.	Are there ridges in your finger nails making them less smooth than is normal?	Yes	No
16.	Does Familial Polyposis or rectal polyps run in your family?	Yes	No

D. Drug-Nutrient Interactions

Do you regularly use any of the following medications or agents? Please indicate Yes or No

1. Laxatives	Yes	No
2. Long term antibiotic therapy	Yes	No
3. Cholesterol - lowering drugs? (any of the following) • Cholestyramine • Colestripol • Questran • Colestid • Atromid-S	Yes	No
4. Anti-gout drug called Colchicine	Yes	No
5. Steroid hormones? (ex. Cortisone, Prednisone)	Yes	No
6. Aspirins for arthritis or any other reason (or other nonsteroidal anti-inflammatory drugs - e.g.. Ibuprofen, Naproxen	Yes	No
7. Antacids	Yes	No
8. Oral contraceptives	Yes	No
9. Sedatives / Barbiturates	Yes	No
10. Alcohol	Yes	No
11. Estrogen Replacement	Yes	No
12. Caffeine	Yes	No
13. Nicotine/Smoking	Yes	No
14. Antidepressants	Yes	No
15. Amphetamines	Yes	No
16. Levo-dopa	Yes	No
17. Anti-convulsants	Yes	No
18. Digoxin	Yes	No
19. Indomethacin	Yes	No
20. Diuretics	Yes	No
21. Antihypertensive - Captopril	Yes	No
22. Antihypertensive - Beta-blockers	Yes	No
23. Statin-Cholesterol-lowering drugs	Yes	No

E. Primary Screening Evaluation for Vitamin and Mineral Supplementation (Possible Contra-Indications)

1. Have you ever had an allergic reaction or an intolerance to Vitamin Supplements in the past?	Yes	No
2. Are you Pregnant?	Yes	No
3. Are you breast feeding?	Yes	No
4. Are you taking a drug called Levodopa (L-dopa)?	Yes	No
5. Are you taking an anticoagulant drug, such as Warfarin or Coumadin?	Yes	No
6. Are you taking an anti-convulsant, anti-seizure or anti-epileptic drug such as Phenytoin or Dilantin?	Yes	No
7. Do you have Sickle Cell Anemia?	Yes	No
8. Do you suffer from Hemolytic Anemia (Glucose - 6 Phosphate Dehydrogenase Deficiency)?	Yes	No
9. Do you suffer from Kidney Failure (Renal Failure)?	Yes	No
10. Have you ever had Kidney Stones?	Yes	No
11. Are you scheduled for surgery in the next month?	Yes	No
12. Have you been diagnosed with Wilson's Disease - copper storage disease? (Hepatolenticular Degeneration?)	Yes	No
13. Have you been diagnosed with Hemochromatosis - iron storage disease?	Yes	No
14. Have you received a transplant of any kind?	Yes	No
15. Do you have a medical condition that is under medical supervision? If yes. please describe_____	Yes	No

F. **Clinical Status- Inflammation and Injury**

1. Do you suffer from chronic pain or injury? Yes No

If yes, please describe the nature and location of the injury(s)?

Additionally, please indicate if any of the following chronic pain disorders apply to you.

__ Fibromyalgia	__ Ulcerative Colitis	__ Complex Regional Pain Syn.
__ Chronic Pain Syndrome	__ Crohn's Disease	__ Carpal Tunnel Syndrome
__ Tendinitis	__ Rheumatoid Arthritis	__ Sciatica
__ Muscle Strain	__ Osteoarthritis	__ Thoracic Outlet Syndrome
__ Chronic Fatigue Syndrome	__ Autoimmune	__ Candidiasis infection
__ Spasms	__ Prostate/Prostatitis	__ Dysmenorrhea
__ Numbness/Tingling	__ Other:_____	

2. How often do you suffer from the pain and/or injury?
   a) Less than once per year
   b) Approximately once per year
   c) A few times per year
   d) Once per month
   e) A few times per month
   f) Once per week
   g) More often than once per week
   h) Constant Pain/Injury

3. What is the typical duration of the pain and/or injury?
   a) Less than one day
   b) Between 2-5 days
   c) Between 6-14 days
   d) Approximately one month
   e) Between 2-6 months
   f) Greater than 6 months
   g) Greater than 1 year

4. Please indicate if the pain and/or injury has impacted your occupational or recreational activities?
   a) Often
   b) Occasionally
   c) Rarely
   d) Never

5. Please indicate if the pain and/or injury has affected your sleep?
   a) Often
   b) Occasionally
   c) Rarely
   d) Never

6. Please indicate if the pain and/or injury require over-the-counter medication?
   a) Yes
   b) Sometimes
   c) No

   Please indicate type/frequency:_____

G. Are Your Health Problems Yeast Connected?

If your answer is "yes" to any question, circle the number in the right hand column. When you've completed the questionnaire, add up the points. Your score will help you determine the possibility (or probability) that your health problems are yeast related.

	YES	NO	Score
1. Have you taken repeated or prolonged courses of antibacterial drugs?	☐	☐	4
2. Have you been bothered by recurrent vaginal, prostate or urinary tract infections?	☐	☐	3
3. Do you feel "sick all over," yet the cause hasn't been found?	☐	☐	2
4. Are you bothered by hormone disturbances, including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature or fatigue?	☐	☐	2
5. Are you unusually sensitive to tobacco smoke, perfumes, colognes and other chemical odors?	☐	☐	2
6. Are you bothered by memory or concentration problems? Do you sometimes feel "spaced out"?	☐	☐	2
7. Have you taken prolonged courses of prednisone or other steroids; or have you taken "the pill" for more than 3 years?	☐	☐	2
8. Do some foods disagree with you or trigger your symptoms?	☐	☐	1
9. Do you suffer with constipation, diarrhea, bloating or abdominal pain?	☐	☐	1
10. Does your skin itch, tingle or burn; or is it unusually dry; or are you bothered by rashes?	☐	☐	1