Return to: National Integrated Health Associates
5225 Wisconsin Ave., NW, #401
Washington, DC 20015. 202-237-7000, Fax: 202-237-0017

Nutritional Assessment Questionnaire

Name:_____ **Date:** _____/____/_____

Birthdate: _____ **Gender**: _____

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

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

PART I

Read the following questions and fill in the number that applies:

KEY: **0 (or leave blank) = Do not consume or use**
1 = Consume or use 2-3 times/month
2 = Consume or use weekly
3 = Consume or use daily

DIET

1. _____ Alcohol
2. _____ Artificial sweeteners
3. _____ Candy or other sweets
4. _____ Carbonated beverages
5. _____ Chewing tobacco
6. _____ Cigarettes
7. _____ Cigars/pipes
8. _____ Coffee
9. _____ Eat fast food regularly
10. _____ Fried foods
11. _____ Luncheon meats/ hot dogs
12. _____ Margarine
13. _____ Milk products
14. _____ Non-herbal tea
15. _____ Refined flour/ Baked goods
16. _____ Refined sugar
17. _____ Vitamins and minerals
18. _____ Water, distilled
19. _____ Water, Tap
20. _____ Water, well
21. _____ Diet often

LIFESTYLE

22. _____ Times you exercise per week (1 = once a week, 2 = 2-4 times/week, 3 = 5 times a week)
23. _____ Changed jobs (3= within last 2 months, 2= within last 6 months, 1= within last 12 months.)
24. _____ Divorced (3= within last 6 months, 2= within last year, 1= within last 2 years)
25. _____ Work over 60 hours/week (3= always, 2= usually, 1= occasionally, 0= never)

MEDICATIONS

Indicate with a checkmark or circle any medications you're currently taking or have taken in the last month:

26. _____ Antacids
27. _____ Antibiotics
28. _____ Anticonvulsants
29. _____ Antidepressants
30. _____ Antifungals
31. _____ Aspirin/Ibuprofen
32. _____ Asthma inhalers
33. _____ Beta blockers
34. _____ Chemotherapy
35. _____ Cortisone
36. _____ Diabetic medications
37. _____ Diuretics
38. _____ Estrogen/Progesterone
39. _____ Heart medications
40. _____ High blood pressure
41. _____ Hormone Therapy
42. _____ Laxatives
43. _____ Insulin
44. _____ Oral/implant contraceptives
45. _____ Radiation exposure
46. _____ Recreational drugs
47. _____ Relaxants/Sleeping pills
48. _____ Thyroid medication
49. _____ Tylenol/acetaminophen
50. _____ Ulcer medications

Other medications and dosages (if known): _____

PART II

Read the following questions and fill in the number that applies:

(How significant is the symptom? How true is the statement? 0 means not at all, 3 means extremely true.)

KEY: **0 (or leave blank) = No or Do not have the symptom, the symptom does not occur**
1 = Yes or It is a minor or mild symptom or it rarely occurs (once a month or less)
2 = It is a moderate symptom or it occasionally occurs (weekly)
3 = It is a severe symptom or it frequently occurs (daily)

Please Answer Each Section Carefully

They relate to different body systems.

Section 1

51. _____ Belching or gas within 1 hr. of a meal
52. _____ Heartburn or acid reflux
53. _____ Bloating shortly after eating
54. _____ Are you a vegan (no dairy, meat, fish or eggs)
55. _____ Bad breath (halitosis)
56. _____ Loss of taste for meat
57. _____ Sweat has a strong odor
58. _____ Stomach upset by taking vitamins
59. _____ Sense of excess fullness after meals
60. _____ Do you feel like skipping breakfast?
61. _____ Do you feel better if you don't eat?
62. _____ Sleepy after meals
63. _____ Fingernails chip, peel or break easily
64. _____ Anemia unresponsive to iron
65. _____ Stomach pains or cramps
66. _____ Diarrhea, chronic
67. _____ Diarrhea shortly after meals
68. _____ Black or tarry stools
69. _____ Undigested food in stool

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Section 2

70. _____ Pain between shoulder blades
71. _____ Stomach upset by greasy foods
72. _____ Greasy or shiny stools
73. _____ Nausea
74. _____ Sea, car or airplane sickness, motion sickness
75. _____ History of morning sickness (1 = yes, 0 = no)
76. _____ Light or clay colored stools
77. _____ Dry skin, itchy feet and/or skin peels on feet
78. _____ Headache over the eye
79. _____ Gallbladder attacks (past or present)
80. _____ Gallbladder removed (1 = yes, 0 = no)
81. _____ Bitter taste in mouth, especially after meals
82. _____ Become sick if drinking wine
83. _____ If drinking alcohol, easily intoxicated
84. _____ Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
85. _____ Recovering alcoholic (1 = yes, 0 = no)
86. _____ Hangovers after drinking alcohol
87. _____ History of drug or alcohol abuse (1 = yes, 0 = no)
88. _____ History of hepatitis (1 = yes, 0 = no)
89. _____ Long term use of prescription medications (1 = yes, 0 =no)
90. _____ Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91. _____ Sensitive to tobacco smoke
92. _____ Exposure to diesel fumes
93. _____ Pain under right side of rib cage
94. _____ Hemorrhoids or varicose veins
95. _____ Nutrasweet (aspartame) consumption
96. _____ Bothered by aspartame (Nutrasweet)
97. _____ Chronic fatigue or Fibromyalgia

Section 3

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

Section 4

115. _____ Anus itches
116. _____ Coated tongue
117. _____ Feel worse in moldy or musty place
118. _____ Taken any antibiotic for a combined time of (1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
119. _____ Fungus or yeast infections
120. _____ Ring worm, "jock itch", "athletes foot", nail fungus
121. _____ Eating sugar, starch or drinking alcohol increases yeast symptoms
122. _____ Stools hard or difficult to pass
123. _____ History of parasites (1 = yes, 0 = no)
124. _____ Less than one bowel movement per day
125. _____ Stools have corners or edges are flat or ribbon shaped
126. _____ Stools are not well formed (loose)
127. _____ Irritable bowel or mucus colitis
128. _____ Blood in stool
129. _____ Mucus in stool
130. _____ Excessive foul smelling lower bowel gas
131. _____ Bad breath or strong body odors
132. _____ Painful to press along outer sides of thighs (Iliotibial Band)
133. _____ Cramping in lower abdominal region
134. _____ Dark circles under eyes

Section 5

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

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)
2 = Moderate symptom, occurs occasionally (weekly)
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Section 6

164. _____ Aspirin is an effective pain reliever (1 = yes, 0 = no)
165. _____ Crave fatty or greasy foods
166. _____ Low or reduced fat diet (past or present)
167. _____ Tension headaches at base of skull
168. _____ Headaches when out in the hot sun
169. _____ Sunburn easily or suffer sun poisoning
170. _____ Muscles easily fatigued
171. _____ Dry flaky skin and or dandruff

Section 7

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

Section 8

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

Section 9

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

Section 10

240. _____ Over 6' 6" tall (Mature height)
241. _____ Early sexual development (before age 10) (1 = yes, 0 = no)
242. _____ Increased libido
243. _____ Splitting type headache
244. _____ Memory failing
245. _____ Ability to tolerate sugar
246. _____ Under 4' 10" (Mature height)
247. _____ Decreased libido
248. _____ Abnormal thirst
249. _____ Weight gain around hips or waist
250. _____ Menstrual disorders
251. _____ Delayed (after age 13) sexual development (1 = yes, 0 = no)
252. _____ Tendency to ulcers or colitis

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Section 11

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

Section 12 – Men Only

269. _____ Prostate problems
270. _____ Urination difficult or dribbling
271. _____ Difficult to start and stop urine stream
272. _____ Pain or burning with urination
273. _____ Waking to urinate at night
274. _____ Interruption of stream during urination
275. _____ Pain on inside of legs or heels
276. _____ Feeling of incomplete bowel evacuation
277. _____ Decreased sexual function

Section 13 – Women Only

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

Section 14

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

Section 15

308. _____ Pain in mid back region
309. _____ Dark circles under eyes and / or puffy eyes
310. _____ History of kidney stones (1 = yes, 0 = no)
311. _____ Cloudy, bloody or darkened urine
312. _____ Urine has a strong odor

Section 16

313. _____ Runny or drippy nose
314. _____ Catch colds at the beginning of winter
315. _____ Mucus producing cough
316. _____ Frequent infections (ear, sinus, lung, skin, bladder, kidney, etc.)
317. _____ Frequent colds or flu
318. _____ Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs., 1 = not in last 2 yrs.)
319. _____ Acne (adult)
320. _____ Itchy skin / dermatitis
321. _____ Cysts, boils, rashes
322. _____ History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue, Hepatitis or other chronic viral condition (1 = yes, 0 = no)

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