RIGHT BALANCE
INTEGRATIVE NUTRITION

# Adult Intake Questionnaire

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges. **To enhance your scheduled consult time, please have this back to me at least 1 day prior to your appointment, if possible. You can scan and email to jen@rightbalancenutrition.com**

Name_____Today's date_____

Address:_____City:_____State:_____Zip:_____

E-mail Address: _____ Fax Number: (_____)_____-_____

Home Phone:(_____)_____-_____Work:(_____)_____-_____Cell:(_____)_____-_____

Birthdate ____/____/____ Age: _____ Place of Birth :_____
month day year city/town (and country if not in US)

Occupation: _____ Referred by: _____

Height: _____' _____" Weight: _____ Sex:_____Desired Weight: _____ Last Age at Desired Weight: _____

Highest Adult Weight:_____What Age?: _____Lowest Adult Weight: _____What Age?: _____

Have you ever dieted?: r Yes r No If Yes, how many times in your adult life? _____

Which diet(s) worked: _____

1. Please check appropriate box:

__African American __Hispanic __Mediterranean __Asian
__Native American __Caucasian __Northern European __Other_____

2. Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

| DESCRIBE PROBLEM | MILD/ MODERATE/ SEVERE | TREATMENT APPROACH | SUCCESS |
|---|---|---|---|
| **Example:** Post Nasal Drip | Moderate | Elimination Diet | Moderate |
| a. | | | |
| b. | | | |
| c. | | | |
| d. | | | |

## 3. PAST MEDICAL AND SURGICAL HISTORY:

| 3. **ILLNESSES** | **WHEN** | **COMMENTS** |
|---|---|---|
| a. Anemia (type) | | |
| b. Arthritis | | |
| c. Asthma | | |
| d. Bronchitis | | |
| e. Cancer | | |
| f. Chronic Fatigue Syndrome | | |
| g. Crohn's Disease or Ulcerative Colitis | | |
| h. Diabetes | | |
| i. Emphysema | | |
| j. Epilepsy, Convulsions or Seizures | | |
| k. Gallstones | | |
| l. Gout | | |
| m. Heart Attack/Angina | | |
| n. Heart Failure | | |
| o. Hepatitis | | |
| p. High Blood Fats (cholesterol, triglycerides) | | |
| q. High Blood Pressure (hypertension) | | |
| r. Irritable Bowel | | |
| s. Kidney stones | | |
| t. Mononucleosis | | |
| u. Pneumonia | | |
| v. Sinusitis | | |
| w. Sleep Apnea | | |
| x. Stroke | | |
| y. Thyroid disease | | |
| z. Other (describe) | | |
| **INJURIES** | | |
| ab. Back injury | | |
| ac. Broken Bones | | |
| ad. Head Injury | | |
| ae. Neck Injury | | |
| af. Other (acute) ex: sprained muscle | | |
| ag. Other (chronic) ex: bad knees | | |
| **DIAGNOSTIC STUDIES** | | |
| ai . Bone Scan | | |
| aj. CAT Scan | | |
| ak. EKG | | |
| al. MRI | | |
| am. Upper/Lower GI Series | | |
| an. Other (describe) | | |
| **OPERATIONS** | | |
| ao. Dental Surgery | | |
| ap. Gallbladder | | |
| aq. Hysterectomy | | |
| ar. Tonsillectomy | | |
| as. Other (describe) | | |

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)
Maternal side:_____
_____
Paternal side:_____
_____

5. Are your parents living? __No __Yes
If no, comment:_____

6. Did you have any health issues as a child? __No __Yes - What age?_____
Describe:_____
_____
_____

7. As a **child,** where there foods you avoided? __No __Yes-(please specify below)

| Food | Symptoms |
|---|---|
| Ex: Milk | Ex: Gas and diarrhea |
| | |
| | |
| | |

8. Please mark in the chart below with information about recent bowel movements:

| **Frequency:** | | **Color:** | |
|---|---|---|---|
| More than 3 times a day | | Dark brown | |
| 2-3 times a day | | Medium brown | |
| One time per day | | Very dark or black | |
| 4-6 times a week | | Greenish | |
| 2-3 times a week | | Blood is visible | |
| Once or fewer a week | | Varies a lot | |
| **Consistency:** | | Yellow, light brown | |
| Soft and well formed | | Greasy, shiny appearance | |
| Often float | | | |
| Difficult to pass | | | |
| Diarrhea | | | |
| Thin, long or narrow | | | |
| Small and hard | | | |
| Loose, but not watery | | | |
| Alternating between hard and loose/watery | | | |

9. Do you experience intestinal gas? (check all that apply)
__present with pain __foul smell __little odor __excessive daily __occasionally

10. Do you experience anal itching? __frequently __occasionally __rarely __never

11. Do you experience any heartburn, chest pressure, or stomach pain? __No __Yes
If yes, do you take anything for relief (list):
_____
_____

## WOMEN ONLY: (Questions 12-21)

12. Have you ever been pregnant? __No __Yes
If yes, please answer the following:
a. Number of miscarriages:_____ b. Number of abortions:_____ c. Number of preemies:_____
d. Number of term births:_____ e. Birth weight of largest baby:_____ Smallest baby:_____
f. Did you develop toxemia? __No __Yes
g. Have you had any other problems with pregnancy? __No __Yes
If yes, describe:_____

13. Age of first mensus:_____

14. Date of last Pap Smear:_____ Normal__ Abnormal__

15. Date of last Mammogram:_____ Normal__ Abnormal__

16. Do you currently use contraception? __No __Yes-(type)_____

17. Are you currently taking birth control pills? __No __Yes-(how long?_____)

If you're on the pill please comment on physical or mental changes from before taking to now:
_____
_____

18. Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)?
__No __Yes-(specify)_____

19. Have you every experienced PMS in the past? __No __Yes – When?: _____

20. Are you still menstruating? __Yes __No - (age of last period:_____)

21. Are you experiencing menopause symptoms? __No __Yes

22. Do you take: __Estrogen __Estrace __Premarin __Other-(specify)_____

23. **(Men and Women)** Do you have urinary problems? __No __Yes
If yes, please specify: __Nightly urination __Frequent day time urination __Hesitancy
__Irregular __Dribbling afterwards __Frequent urge to urinate __Difficulty
__Feeling of incomplete emptying __Burning sensation

24. **(Men Only):** Do you have prostate swelling? __No __Yes

## DENTAL,etc.:

25. Do you have amalgam (silver, black or grey) fillings? __No __Yes (how many? _____)

26. Have you every had fillings replaced?
__No __Yes-(how many?_____when?_____with what material?_____)

27. Do you have root canals? __No __Yes (how many? _____) Any Problems? _____

28. Have you had any cavities in the last 2 years? __No __Yes (how many? _____)

29. Do your gums ever bleed? __No __Yes-(how often?_____)

30. Do you ever grind your teeth? __No __Yes

31. Do you have any artificial joints or implants anywhere in the body or mouth? __No __Yes

## SOCIAL:

32. How well have things been going for you lately?:

| | Great | Good | Could be better | Not very good | Does Not Apply |
|---|---|---|---|---|---|
| a. school | | | | | |
| b. job | | | | | |
| c. social life | | | | | |
| d. close friends | | | | | |
| e. sex | | | | | |
| f. your attitude | | | | | |
| g. boy/girlfriend | | | | | |
| h. children | | | | | |
| i. parents | | | | | |
| j. spouse | | | | | |

33. With whom do you live? List age of children, if any.

_____

_____

34. What is the attitude of those close to you concerning your health?
__Supportive __Not supportive __Indifferent

35. Are you currently married, or have you ever been married? __No __Yes
If yes, when _____ If yes, spouse's occupation: _____
Have you been separated or divorced? __No __Yes - If yes, when? _____

36. What are your hobbies and leisure activities?_____

_____

37. Describe previous jobs/work:_____

38. Have you lived outside of the United States? __No __Yes If yes, where/when? _____

39. What is your total amount of airline trips, in the last year?_____
Estimated total in life:_____ How many out of the country: _____

40. Have **you** experienced any major losses in your life? __No __Yes
If so, please comment:_____

_____

41. Have you or your **family** recently experienced any major life changes (such as a job change)? __No __Yes
If yes, please comment:_____

_____

42. Have you ever had psychotherapy or counseling? __No __Yes
If yes, what kind?_____when? _____
Additional comments: _____

_____

_____

## LIFESTYLE:

43. How important is religion (or spirituality) to you?
__Not at all important __Somewhat important __Extremely important

44. Do you meditate? __occasionally __often __never

45. How much control do you feel you have over your current state of health? Rate 1-10 (none-all)_____
Comment:_____
_____

46. How much time have you lost from work or school in the past year due to illness?
__0-2 days __3-5 days __6-14 days __more

47. What is your usual bed time?_____wake time?_____

48. How well do you sleep? (check all that apply)
__Adequate-(sleep through the night) __Wake up feeling well rested
__Trouble falling asleep __Wake up still tired
__Trouble staying asleep-(How many times do you wake during the night?_____)

49. Check off typical bedtime activities:
__Watch television __Read a book __Listen to music __Bed time snack
__Meditate __Bathe/shower __Drink alcohol __Drink caffeinated beverage
__Other-(specify)_____

50. Do you ever need to take a sleep aid? __No __Yes – Which ones at what dose?
_____
How often_____

51. Do you exercise regularly now? __No __Yes-(specify): Have you in the past? __No __Yes
__Once per week __2 times per week __3 times per week __ 4 times per week or more
Amount per session: __less than 15 minutes __15-30 minutes __30-45 minutes __> 45 minutes
__Other-(specify)_____

52. What type of exercises do you do currently
__Jogging __Walking __ Weight training __Water sports __Aerobics __Yoga
__Other-(specify)_____

53. Do you get sun exposure? __No __Yes-(specify) __Daily __Weekly How much? _____

54. Do you wear sun block? __No __Yes-(percentage of time_____)

## ALLERGY & TOXIC POTENTIAL:

55. Do you have any pets or farm animals? __No __Yes - List: _____
If yes, where do they live? __Indoors __Outdoors __Both

56. Do odors such as perfume, cleaning solutions, smoke, etc. affect you? __No __Yes
If yes, explain:_____
_____

57. Have you, to your knowledge, been exposed to toxic metals at your job or at home?
__No __Yes: __Lead __Cadmium __Arsenic __Mercury __Aluminum
Explain:_____

58. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?
__No __Solvents __Paints __Pesticides __Petrochemicals
__Coal __Hydrocarbons __Mold __Other (specify):_____

59. Do you now or have you recently lived in an older home (pre 1970's)?: __No __Yes
If yes, how old is/was home: _____ How long have/did you live there? _____

60. Have you ever lived or worked in a water damaged building? __No __Yes
If yes, when? _____ How long? _____

61. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes?
__No __Yes-(explain)_____
How often do you wear dry cleaned clothing? _____

62. Do you have a regular lawn care service? __No __Yes-(how often?_____)

63. Do you regularly spray for pests outdoors? __No __Yes-(how often?_____)

64. Do you use bug spray (outside) or insecticides (indoors) on a regular basis? __No __Yes

65. How often are you exposed to burning coal, bonfires, fire pits, etc.?_____

66. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?
__No __Yes- Currently: __1-3 drinks per week __4-6 __7-10 __10 or more
__Yes- In the past: __1-3 drinks per week __4-6 __7-10 __10 or more
If you have quit, when?_____

67. Have you ever used tobacco? __No __Yes-(specify:_____) If yes, number of years:_____ Amount per day:_____ Year quit?_____

68. Are you now or were you ever regularly exposed to second hand smoke? __No __Yes When? _____

69. Have you ever used recreational drugs? __No __Yes-(specify:_____)

## MEDICATIONS:

70. What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

| Medication Name | Purpose | Dosage | Start Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

71. Do you take any other over the counter medications on an **occasional basis**?
If yes, which one(s)?_____
_____

72. How many times have you taken antibiotics as an infant or child?
__Less than 5 times __More than 5 times __More than 10 time __So many times I lost count
Reason:_____

73. As an adult, how often do you take antibiotics?
__Never __Once a year (on average) __1-3 times a year (on average)
__Longer-(explain)_____
Why?_____

74. Were you ever on antibiotics for a prolonged period of time? __No __Yes
If yes, explain:_____
_____

75. Fill in the chart below for how many times have you taken oral steroids (e.g. Cortisone, Prednisone, etc.)?

| | Less than 5 times | Greater than 5 times | Greater than 10 times |
|---|---|---|---|
| Infancy/Childhood | | | |
| Teen | | | |
| Adulthood | | | |

76. List all vitamins, minerals, and other nutritional supplements that you are currently taking.
Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

| Vitamin/Herbal Supplement(s) | Brand | How Many and When? | Start Date |
|---|---|---|---|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |
| 9. | | | |
| 10. | | | |
| 11. | | | |
| 12. | | | |
| 13. | | | |
| 14. | | | |

## DIETARY HABITS:

77. Do you avoid certain foods for any reason? __No __Yes
Which foods and why? _____
_____
_____

78. Are you currently on a special diet (i.e., vegetarian, South Beach, etc)? __No __Yes
If yes, how long and describe:_____
_____

79. Usual Breakfast time:_____Lunch time:_____Dinner time:_____
Snack time: _____ Snack time: _____ Snack time:_____

80. Please list the foods you typically have at the following meals:
Breakfast _____
Snack _____
Lunch _____
Snack _____
Dinner _____
Snack _____

81. Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.? __No __Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea)_____
_____
_____
_____

82. Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*
__No __Yes
If yes, specify: _____
_____

83. How much of the following do you consume on average?

| Food | Amount Per Day | Amount Per Week |
|---|---|---|
| Candy | | |
| Cheese | | |
| Chocolate | | |
| Cups of caffeinated coffee | | |
| Cups of decaffeinated coffee | | |
| Cups of hot chocolate | | |
| Cups of tea (containing caffeine) | | |
| Diet sodas (cans) | | |
| Regular soda (cans) | | |
| Ice cream | | |
| Salty snacks | | |
| Slices white bread/rolls/1/2 bagel | | |
| Nuts | | |

84. Do you feel **much worse** when you eat any of the following: (check all that apply)
__high fat foods __refined sugar (junk foods) __high protein foods __fried foods
__high carbohydrate foods __1 or 2 alcoholic drinks
__(breads, pastas, potatoes) __Other (specify):_____

85. Do you feel **much bette**r when you eat a lot of: (check all that apply)
__high fat foods __refined sugar (junk foods) __high protein foods __fried foods
__high carbohydrate foods __1 or 2 alcoholic drinks
__(breads, pastas, potatoes) __Other (specify):_____

86. Do you feel **worse** at certain times of the year? __No __Yes-(when?_____)
How do you feel?_____

87. Do you feel **better** at certain times of the year? __No __Yes-(when?_____)
How do you feel?_____

88. Does skipping a meal affect you in any way? __No __Yes – Explain: _____
_____
_____

89. Do you ever crave or "binge" on certain foods? __No __Yes
Which foods, how often and comment on possible stressors/triggers? _____
_____
_____
_____

90. How many times a week do you eat out? _____
Rate the type of restaurants you frequent in order of most to least often (1 being the kind you eat at most often, and 5 for the least often (or never)
____Fast food ____ fine dining _____ café _____ coffee shop or Corner bakery type place
____ Casual dining ____ breakfast dinner ____ grocery store deli ____ health food store deli

91. Are you the primary cook for the household? _____. If not, who is? _____
92. On a scale of 1-5, rate what extend you enjoy preparing/cooking food (1 – a lot, 5 – hate it!) _____
93. Where do you do the bulk of your grocery shopping? _____
94: What percentage of your food intake is Organic? _____
95: Do you drink bottled water? ____ if yes, appox how many bottle per day _____? What size? _____

96. Is there anything else you think I should know? What do you hope to get out of your visit?
_____
_____
_____
_____