FUNCTIONAL NUTRITION DIETARY QUESTIONNAIRE

Name:	Age:	Date:

Personal Health Profile:

Any problems you have **NOW** rate **1(mild) to 5 (severe).** For problems that you have had in the past please place a "√" mark in the space next to it.

_______Acid Indigestion
_______Allergies
_______Asthma
_______Bloating
_______Bronchitis
_______Cold Feet / Hands
_______Constipation
_______Chronic Fatigue
_______High Cholesterol
_______Depression
_______Diabetes
_______Dizziness or Fainting
_______Flatulence (gas)

_______Headaches
_______Heart Arrhythmia
_______Hemorrhoids
_______Hot or Burning Feet
_______High or Low Blood Pressure
_______Hypoglycemia
_______Indigestion
_______Insomnia
_______Low Blood Pressure
_______Migraines
_______Mononucleosis
_______Mucus or Congestion
_______Muscle or Joint Pain

_______Nausea
_______Nerve Pain or Numbness
_______Night Sweats
_______Parasites
_______Sciatica
_______Sleeping Disorder
_______Sinusitis
_______Stress or Anxiety Attacks
_______Toe Fungus, Dry Feet or Chapped/Cracking Heels
Other problems: ______________
____
____

Metabolism / Absorption / Digestion:

Rate your overall energy (circle one -- 10 best): 1 2 3 4 5 6 7 8 9 10
Rate your overall diet: 1 2 3 4 5 6 7 8 9 10

Do you feel energized after you eat? (Circle one of the following) ALWAYS OFTEN SELDOM NEVER
How many cups of water do you drink daily:___________Type of water: ______________How many bowel movements daily? _____ How long does bowel elimination take? ________ My bowels are (circle) one: HARD FIRM LOOSE

Sleep, Recovery & Regeneration:

Do you ever experience muscle cramps while sleeping?	YES	NO
Do you ever experience subtle or quick phantom muscle pains while sleeping or during the daytime?	YES	NO
Do you typically wake up at night?	YES	NO
Do you take anything to help you sleep?	YES	NO
If you wake up at night is it hard for you to fall back asleep?	YES	NO

How many naps do you take per day? ________
Average hours of uninterrupted sleep per night: ________
How many hours does it take to fall asleep? ________

Immunity:

Rate the degree of stress you are under (0 – 10max): 0 1 2 3 4 5 6 7 8 9 10
Rate yourself on how well you handle stress (10 is best): 0 1 2 3 4 5 6 7 8 9 10

Number each of the following:
Alcohol/caffeine (coffee, tea, etc) drinks per day: __________
Sugar servings per day (soft drinks, ice cream, sports drinks, sweets, etc): ________
Tobacco per day: _________
Total steroid prescription drugs or injections in last 5years: ______________________________________

Genetic Health:

Circle any disease in mother's family line:	CANCER	HEART DISEASE	DIABETES	OTHER	N/A
Circle any disease in father's family line:	CANCER	HEART DISEASE	DIABETES	OTHER	N/A

Do any of your immediate family members have health problems? YES NO
Please provide brief details on any family health issues or disease related deaths:

____
____
____
____

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Dietary Analysis:

Describe your TYPICAL DAILY MEALS & FLUID INTAKE:	Dietitian & Nutritionist NOTES:
Breakfast: ______________	______________
______________	______________
______________	______________
Morning snack: ______________	______________
______________	______________
Lunch: ______________	______________
______________	______________
______________	______________
Afternoon Snack: ______________	______________
Dinner: ______________	______________
______________	______________
______________	______________
Bedtime Snack: ______________	______________
______________	______________

Medications/Supplements: (Please include dosage

Name: ______________ Dosage: ______________ Times per day: ______________
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If more than 5 medications or Supplements please attach sheet or write on back of questionnaire form.

General:

How many times a week do you eat out? _______ How late do you eat dinner? _________ Who makes your meals at home? _________ Do you enjoy fruits & veggies? YES NO Do you have any known food allergies? YES NO
If you have any known food allergies please list and explain common symptoms? ______________

____

____

Are you an overeater? YES NO Are you a stress eater? YES NO If so, when / how does it affect you?

____

____

Have you ever developed a dietary strategy? YES NO Do you have food cravings/addictions? YES NO
(Explain)______________________________

____

If you struggle with weight challenges, please explain? ______________________________

____

____

How motivated are you to make dietary changes? (explain below) 1 2 3 4 5 6 7 8 9 10

____

____

How motivated are you to perform “athletically” to your greatest potential (10 is best)? 1 2 3 4 5 6 7 8 9 10
How important do you believe your “diet & hydration” is to your athletic performance? 1 2 3 4 5 6 7 8 9 10
How important do you believe your “health” is to maximizing your athletic performance? 1 2 3 4 5 6 7 8 9 10