Backbone of Healthcare
308-872-2171 Fax: 308-872-6093

Nutrition Appraisal Questionnaire

Date______________

-To be filled out to the best of your ability upon making your nutritional consultation appointment. Your careful consideration of these questions will help us establish an accurate picture of your current state of health and identify any possible underlying causes of illness. The more details you can provide, the more effective we will be in formulating a tailored treatment plan.

1. **Past & Current Relevant Medical History**

-name_____________________________________-date of birth ________________________
-phone number_______________________-email address______________________________
-address____
-sex ____ethnic background___________________

For Office Use:	
-BP______________	height_____________________________________
-0²_______________	weight_____________________________________
-pulse____________	Other lab results available _____________________
-respiration_______	____
	____

-list your most important health concerns/complaints/symptoms

-include-date of onset, severity, duration, what gives relief, what makes it worse

1____
____
____
2____
____
____
3____
____
____

-important events that may have contributed to the above conditions _____________________
____
____

-other healthcare practitioners seen in regards to these problems-when, duration and results
____
____
____

-previous medical conditions, surgeries, hospitalizations and diagnostic procedures _________
____
____
____

-allergies-childhood and current ____
____

2. **Dietary Intake**

-describe typical daily food intake, include amounts and time of day
Breakfast____
Lunch____
Dinner____
Snacks____
Fluids____

-food allergies or sensitivities ____
____
-are you currently on a special diet, please explain______________________________________

3. **Medications & Supplements –**

-*purpose* - *name brand* - *dosage* - *frequency* -*duration of use*

-**current** prescriptions ____
____
____
____
____

-**current** OTC medications____
____
____
____

-**current** supplements (vitamins, minerals, herbals) _______________________________________
____
____
____

-**past** prescriptions & when ____
____
____

-**past** OTC medications & when ____
____
____

-**past** supplements & when____
____
____

4. **Family History-**

-immediate biological family history of disease, conditions, symptoms, genetic predispositions (who, what and when) ____
____
____
____

-extended biological family history of disease (who, what and when)_________________________
____
____
____

-birth information-premature, low birth weight, etc. ___________________________________
____

5. **Possible Environmental Contributors (chemical or emotional)**

-workplace exposure or stress ____
____

-home exposure or stress ____
____

-other exposure or stress-timing, frequency and amount of smoking, tobacco, caffeine, drug and alcohol use
____
____

6. **Physical Activity/Lifestyle**
-current-daily activity-type and duration ____
____
____
-weekly activity-type and duration ____
____
____
-past-daily activity-type and duration ____
____
-weekly activity-type and duration ____
____
____
-**restrictions** to activities of daily living ____
____

7. **Social History**
-married or single _______________-number of children _______________________________
-education ____
____
-employment-current and recent ____
____
-free time activities ____
____
-when and where have you traveled out of the US ____
____
-recent major loses or life changes ____
____

8. **Organ System Review**
-history of dysfunction of any organ system of concern to primary condition - (ex. heart, liver, kidney, digestive…) ____
____
____
____

9. **Please include any other concerns or questions that have not been addressed in this form and include anything that we should know about your case history that was not covered.**
____
____
____

Responses will determine further specific health appraisal questionnaires or testing should be completed.

~If you don't take time for your health today, you won't have health for your time tomorrow.~