Nutritional
Weight & Wellness

Health Questionnaire

Health Survey

Questions with asterisk (*) are required. NOTE: Do not copy/paste answers into any form fields, simply type in your responses. Do not use the enter/return key when typing in form fields.	
Today's Date:	**Appointment Date:**
Please select the location of your appointment: ❑ Eagan ❑ North Oaks ❑ Wayzata	❑ Maple Grove ❑ St. Paul ❑ Woodbury
Nutritionist:	**Client's Full First Name:**
Client's Full Middle Name:	**Client's Full Last Name:**
Date of Birth:	**Age:**
Gender:	**Parent or Guardian Name (if client is a minor)**
Address:	
City:	**State:**
Country	**Zip:**
Phone (Primary):	
This phone number is your: ❑ Mobile ❑ Home ❑ Work	
Phone (Secondary):	
This phone number is your: ❑ Mobile ❑ Home ❑ Work	
I understand that any phone number I give to Nutritional Weight & Wellness, Inc. verbally or written, can be used to leave voice mail messages. ❑	
Email:	
Email will be used for reminders and notifications.	
Height	**Weight:**
Reason and goals for consultation:	

Health History

Please check any that apply to you (past or present)

	Past	Present		Past	Present
Acne	❑	❑	**Headaches**	❑	❑
ADD / ADHD	❑	❑	**Heart disease**	❑	❑
Addiction (alcohol or drugs)	❑	❑	**Heartburn, Acid Reflux**	❑	❑
Allergies	❑	❑	**Hemorrhoids**	❑	❑
Anemia	❑	❑	**Herpes simplex**	❑	❑
Anorexia or Bulimia	❑	❑	**High blood pressure**	❑	❑
Anxiety or nervousness	❑	❑	**High cholesterol**	❑	❑
Arthritis	❑	❑	**HIV**	❑	❑
Asthma	❑	❑	**Hot flashes**	❑	❑
Bed wetting	❑	❑	**Hypoglycemia**	❑	❑
Bladder infections	❑	❑	**Insomnia**	❑	❑
Bloating, gas	❑	❑	**Intestinal problems**	❑	❑
Blood sugar problems	❑	❑	**Kidney stones**	❑	❑
Bronchitis	❑	❑	**Liver problems**	❑	❑
Cancer	❑	❑	**Memory loss or confusion**	❑	❑
Celiac disease	❑	❑	**Nails, poor growth**	❑	❑
Colds or flu (frequent)	❑	❑	**Nails, white spots**	❑	❑
Cold sores	❑	❑	**Osteopenia/Osteoporosis**	❑	❑
Chronic fatigue	❑	❑	**Panic attacks**	❑	❑
Constipation	❑	❑	**Parasites**	❑	❑
Cradle cap	❑	❑	**Pregnant/nursing mother**	❑	❑
Dandruff	❑	❑	**Psoriasis**	❑	❑
Depression	❑	❑	**Respiratory problems**	❑	❑
Diabetes (Type I)	❑	❑	**Ring in ears**	❑	❑
Diabetes (Type II)	❑	❑	**Seizures**	❑	❑
Diarrhea	❑	❑	**Severe mood swings**	❑	❑
Difficulty losing weight	❑	❑	**Skin conditions**	❑	❑
Difficulty gaining weight	❑	❑	**Spider Veins**	❑	❑
Ear infections	❑	❑	**Stomach Aches**	❑	❑
Eczema	❑	❑	**Stroke**	❑	❑
Emotional instability or sensitivity	❑	❑	**Suicidal tendencies**	❑	❑
Emphysema	❑	❑	**Thyroid condition**	❑	❑
Fainting	❑	❑	**Ulcer**	❑	❑
Gall bladder problems	❑	❑	**Varicose Veins**	❑	❑
Gout	❑	❑	**Yeast infections**	❑	❑
Hair loss or poor hair growth	❑	❑			

Health History

Cholesterol:	**Blood Pressure:**

Women: please check any that pertain

- ❑ PMS
- ❑ Painful periods
- ❑ Birth control pills (past or present use)
- ❑ Menopause
- ❑ Hysterectomy
- ❑ Irregular periods
- ❑ Loss of periods
- ❑ Loss of libido
- ❑ Painful intercourse
- ❑ Children

If children, how many:	**Ages:**

Men: please check any that pertain

- ❑ Frequent urination
- ❑ Difficulty with urination
- ❑ Difficulty with erections
- ❑ Loss of libido
- ❑ Prostate enlargement

If Appointment is for your child:

Describe concentration, activity level, and behavior:

List any behavior issues:

Diet Review

Describe a typical day's meals (include all foods eaten, drinks, and times consumed). Be as specific as you can.

Breakfast:

Usual time:

Lunch:

Usual time:

Dinner:

Usual time:

Snacks:

Usual time(s):	**How many times do you usually eat per day?**

Do you drink?

	If yes	**how many 8 oz. per day?**
Water	❑	
Coffee	❑	
Soda	❑	
Fruit juice	❑	
Tea	❑	

If you drink tea, what type:

Do you drink alcohol?

- ❑ Yes
- ❑ No

If yes, how many drinks per day/week/month?

Diet Review

Do you get noticeably irritable, light-headed, or weak if you haven't eaten in a while?

❑ Yes ❑ No

Do you often skip meals?

❑ Yes ❑ No

If yes, which do you most commonly skip?

What time(s) of the day are you most hungry?

Do you crave (check all that apply):

❑ Sugar ❑ Chocolate
❑ Desserts ❑ Fried foods
❑ Meat ❑ Milk
❑ Fat ❑ Alcohol
❑ Bread ❑ Other

If other, please list:

Do you consume (check all that apply):

❑ Butter ❑ Margarine
❑ Olive oil ❑ Coconut oil
❑ Soybean oil ❑ Peanut oil
❑ Corn oil ❑ Crisco®
❑ Vegetable oil ❑ Canola oil
❑ Mayonnaise ❑ Other

If other, please list:

What are your favorite foods?

What foods do you strongly dislike?

Are you currently under a physician's care for a chronic health problem that requires continuous monitoring?

❑ Yes ❑ No

If yes, please explain:

Do you take any nutritional supplements or vitamins? If yes, please list: (Please bring your supplements to your appointment so that your nutritionist knows the amount and type of nutrients you are currently taking.)

Please list your current medications and the health conditions for which you are taking them

Medication	Health Condition

Antibiotic use:

❑ Less than once a year ❑ More than 2 times per year ❑ Hardly ever ❑ Never

Reason for antibiotic use:

Diet Review

Steroid use (Cortisone or Prednisone)
❑ Frequent ❑ Rare ❑ Never

Please list any disease, illness, or ailments in your immediate family.

Please feel free to expand on any concerns you feel are relevant to your health.

Are you sensitive to any of the following foods? Please check all that apply.
❑ Gluten ❑ Soy ❑ Nuts ❑ Other
❑ Dairy

If other, please expain:

Do you have a family history of addiction?
❑ Alcohol ❑ Drugs or Medications ❑ Food ❑ Tobacco

Lifestyle Factors

Occupation:	**Work Hours:**

Do you exercise?
❑ Yes ❑ No

If yes, what kind?

How frequently do you exercise?

Please rate the following:

Daily energy level:
❑ Excellent ❑ Good
❑ Fair ❑ Poor

Daily stress level:
❑ Very high ❑ High ❑ Moderate ❑ Low
❑ None

Energy after exercise:
❑ Excellent ❑ Good ❑ Fair ❑ Poor
❑ Not applicable

General enjoyment of life:
❑ Excellent ❑ Good
❑ Fair ❑ Poor

Do others consider you:
❑ Inactive ❑ Active ❑ Very active

Are you:
❑ Often tired
❑ Occasionally tired
❑ Rarely tired

How much sleep do you get each night on average?

Any problems sleeping?

Do you smoke?
❑ Yes ❑ No

Lifestyle Factors

Have you recently quit smoking?
❑ Yes ❑ No

Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke:
❑ Moderate to severe symptoms ❑ Mild symptoms ❑ No symptoms

How is your dental health?
❑ Good
❑ Fair
❑ Poor

How often do you have bowel movements?	**How often do you urinate?**

How often do you eat out?

Which restaurants?

Do you eat:
❑ Alone
❑ With friends
❑ With spouse/significant other

If weight loss is one of your goals, please complete the following questions. If weight loss is not one of your goals, please continue to the next page using the button at the bottom of the page

Do you feel you've always had a weight problem?
❑ Yes ❑ No

If yes, around what age did you first notice that you had gained weight?

What do you feel your weight gain was caused by?

What diets have you tried in the past?

Have you ever had any health problems as a result of dieting?
❑ Yes ❑ No

If yes, what problems?

Please list any surgeries you've had:

Health Survey

Rate each of the following symptoms based upon your health profile for the past 6 months. Add up totals for each of the sections.
Point Scale:
0 = Never or Almost Never have the symptoms
1 = Occasionally have it, effect is Not Severe
2 = Occasionally have it, effect is Severe
3 = Frequently have it, effect is Not Severe
4 = Frequently have it, effect is Severe

Digestive **Nausea or vomiting** **Diarrhea** **Constipation** **Bloated feeling** **Belching, passing gas** **Heartburn** **Total**	**Ears** **Itchy Ears** **Earaches, ear infections** **Drainage from ear** **Ringing in ears** **Hearing loss** **Total**	**Emotions** **Mood swings** **Anxiety, fear, nervousness** **Anger, irritability** **Depression** **Acting out, aggressive** **Total**
Eyes **Watery, itchy eyes** **Swollen, red, or sticky eyelids** **Dark circles under eyes** **Blurred or tunnel vision** **Total**	**Heart** **Skipped heartbeats** **Rapid heartbeats** **Chest pain** **Shortness of breath** **Total**	**Lungs** **Chest congestion** **Asthma, bronchitis** **Difficulty breathing** **Total**
Mind **Poor memory** **Confusion** **Poor concentration** **Poor coordination** **Difficulty making decisions** **Stuttering, stammering** **Slurred speech** **Learning problems** **Total**	**Mouth / Throat** **Chronic coughing** **Gagging, clears throat frequently** **Sore throat, hoarse** **Cavities, tooth decay** **Swollen, discolored tongue, gums, or lips** **Canker sores** **Total**	**Nose** **Snoring** **Stuffy nose** **Sinus problems** **Sinus drainage** **Allergies** **Sneezing attacks** **Excessive mucus** **Total**
Skin **Acne** **Hives** **Rashes** **Dry skin** **Total**	**Head** **Headaches** **Faintness** **Dizziness** **Total**	**Joints / Muscles** **Pain or aches in joints** **Arthritis** **Stiffness, limited movement** **Muscle cramps** **Weakness or tiredness** **Total**

Health Survey

Weight	Low Energy	Excess Energy
Binge eating or drinking	Sluggishness, low energy	Hyperactive
Craving certain foods	Lack of interest, apathy	Restless, fidgety
Excessive weight	Difficulty waking	Out of control
Compulsive eating	Can't stay awake	Total
Water retention	Feeling tired or weak	
Underweight	Total	
Insulin resistant / pre-diabetic		
Total		
Hormonal	**Sleep**	**Other**
Delayed puberty	Difficulty falling asleep	Frequent illness
Premature puberty	Difficulty staying asleep	Frequent or urgent urination
PMS, cramps	Sleep walking	Genital itch, discharge
Hot flashes / night sweats	Nightmares	Total
Total	Bedwetting	
	Insomnia	
	Total	

Add up the totals for each section to arrive at the grand total.

Grand Total

Cravings Inventory

Please complete this inventory to help us determine the origin of your cravings.

Blood Sugar

	Please Check all that apply		Please Check all that apply
At a restaurant, I almost always eat too much bread, even before the meal is served.	❑	**I have periods of anxiety throughout the day.**	❑
Before going to dinner at a friend's house, I will sometimes eat something in case dinner is delayed.	❑	**I'm hungry all the time.**	❑
I get sleepy, almost a "drugged" feeling after eating a large meal containing bread, pasta or potatoes and dessert, whereas I feel more energetic after a meal of only meat and salad.	❑	**Before my cycle, I'm always looking for carbs.**	❑
At times, I wake in the middle of the night and can't get back to sleep without a snack.	❑	**I drink several glasses of milk a day.**	❑
I get tired and/or hungry in the mid·afternoon.	❑	**I crave peanut butter and sour cream.**	❑
If I have a breakfast containing carbohydrates, it is harder for me to control my eating for the rest of the day than it would be if I had coffee or nothing at all.	❑	**I can't stop eating cheese once I start.**	❑
If I don't eat frequently, I get shaky or irritable.	❑		

Mineral Deficiencies

	Check all that apply		Check all that apply
I crave chocolate-the more, the better.	❑	**I have trouble sleeping through the night.**	❑
After a meal of meat, vegetables and healthy fat, I need sugar or a sweet treat.	❑	**I have low thyroid function.**	❑
I chew ice constantly.	❑	**I cry easily, my legs are weak, and I feel tired.**	❑
I have muscle cramps.	❑	**I salt everything.**	❑

Cravings Inventory

Neurotransmitters

	Check all that apply		Check all that apply
Once I start eating sweets, starches or snack foods, I often have a difficult time stopping.	❑	**I have a family history of addiction.**	❑
I crave soda, particularly diet soda.	❑	**I have many obsessive behaviors.**	❑
If I'm feeling down, a snack of cake or cookies will make me feel better.	❑	**I have very low self·esteem.**	❑
Now and then, I think I am a secret eater.	❑	**Eating one brownie leads me to finish the whole pan.**	❑
I constantly think about food .	❑	**I find that I'm craving wine more every day.**	❑
I feel out of control with my eating.	❑		

Intestinal Health

	Check all that apply		Check all that apply
I'm a picky eater.	❑	**I have heartburn and other digestive issues.**	❑
I'm not hungry for breakfast.	❑	**After finishing a full meal, I sometimes feel that I could go back and eat the whole meal again.**	❑
I've been on antibiotics for acne or other health problems.	❑	**If potatoes, bread, pasta or dessert are on the table, I will often skip eating vegetables or salad.**	❑
I've been on anti-inflammatory medications such as prednisone or Celebrex or ibuprofen.	❑	**My favorite foods are bread, cereal and pasta.**	❑
I am lactose intolerant.	❑	**I'm hungry all the time.**	❑
I have gluten sensitivity.	❑	**I don't like the taste of meat.**	❑

What other cravings do you have?

Waiver and Release of Liability, Privacy Practices & Payment Terms & Policy

To submit forms please check each box, type (sign) your name and then click "Submit Forms."

Waiver and Release of Liability

I agree and understand that during and after participating in nutrition counseling from Nutritional Weight & Wellness, Inc.:

I understand that Nutritional Weight & Wellness, Inc. provides no guarantee or assurances that through nutrition counseling I will achieve my wellness goals, lose weight, or overcome or avoid health issues, such as cardiovascular disease or diabetes. ❑

I assume all responsibility and any risks associated with the nutritional choices that I make. I agree to hold Nutritional Weight & Wellness, Inc. and its counselors harmless and release them from any liabilities associated with recommendations and information given by them to me relating to dietary changes or nutritional supplements. I specifically recognize and agree that I have been advised by Nutritional Weight & Wellness, Inc. that dietary changes and/or the taking of nutritional supplements may have differing effects on individuals. I understand that with respect to changes in my diet or in my nutritional practices it is recommended that I consult with my physician. ❑

I understand that the nutritional counseling provided is not considered to be medical advice and that I am encouraged to continue to pursue medical care with my health care provider. ❑

Privacy Practices
You have the right to review Nutritional Weight & Wellness, Inc.'s Notice of Privacy Practices. To review this document click here.

I acknowledge that I have been offered or received a copy of the Notice of Privacy Practices. ❑

I consent to the release of my health records and other information related to healthcare services received at Nutritional Weight & Wellness, Inc. for the purpose of treatment, payment, and healthcare operations. The Notice of Privacy Practices describes such uses and disclosures more completely. We are required to obtain your consent before we release your health records to other providers. ❑

I understand that this consent will continue forever unless it is canceled by writing and sent to Nutrition Weight & Wellness, Inc. at 45 Snelling Ave N, St. Paul MN 55104. ❑

Payment Terms & Policy

For private-pay appointments, payment is due at the end of each appointment.

For insurance appointments, deductibles, co-pays and co-insurance payments are due after the Explanation of Benefits is available. If Nutritional Weight & Wellness, Inc. submits a claim to insurance and your claim is denied, you will be responsible for the full insurance rate.

Nutritional Weight & Wellness, Inc. accepts cash, checks, VISA, MasterCard, Discover and American Express.

Any past due accounts over 90 days will be sent to a collection agency.

Having read and understood the above statements and having had the opportunity to ask questions regarding the meaning and effect of this Waiver and Release of Liability, Privacy Practices & Payment Terms & Policy, my signing is voluntary.

I agree with the above terms. ❑

Date:

By typing your name below, you certify that you have read and agreed to the terms listed above.

My electronic signature will serve as my agreement and act as a physical signature.

Signature of Participant or Guardian: