



NUTRITIONAL QUESTIONNAIRE

First Name: _____ Last Name: _____

Preferred Name: _____ Prefix/Title: _____

Cell: _____ Home: _____

Address: _____
(Street) (City, Province) (Postal Code)

Date of Birth: _____ Gender: _____ Sex: M / F
(DD / MM / YYYY)

Alberta Health Number: _____ Guardian: _____

Emergency Contact Phone: _____ Emergency Contact Name: _____

Emergency Contact Relationship: _____

=====

Family Doctor: _____

Family Doctor Phone: _____ Family Doctor Email: _____

Name of referring professional: _____

Referring Prof. Phone: _____ Referring Prof. Email: _____

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Nutritional Questionnaire:

**** Important please read******

We first want to thank you for taking the time to fill out this paperwork.

This may take you a while to fill out due to all the questions we ask. Anticipate about 1 hour to complete. Take breaks if necessary. The reason this is important is to get a sense of what is truly affecting your health. This also gives our doctors a whole perspective of what's going on. You may notice some questions repeat and that is because some symptoms have multiple causes and the questionnaire is laid out to bring our attention to all the potential causes.

By filling it out before hand, completely and honestly, we have the opportunity to review your case, understand what's affecting you and create a plan for your assessment. When you get to our office we spend more time on refining our questions for you and have a good understanding of what tests will help us figure out the cause of your problems. It also gives you the opportunity to be completely heard.

Please do send this in WELL BEFORE your appointment so that we can have the time to properly read through your paperwork before you get to our office. Same day completion is not sufficient time for review ... unless the doctor has told you otherwise.

Thank you.

List you chief complaints in order of importance to you.

Provide a detailed narrative (story) of your health history in a timeline sequence.

List all diagnoses given to you in a timeline sequence and your personal opinions about the diagnosis.

List all healthcare providers you have consulted and their opinions and treatment about your case.

List any treatments, medications or supplements that have improved your health.

List any treatments, medications or supplements that have caused reactions or a decrease to your health.

List ALL current medications, herbs, vitamins, supplements, etc.

List in a timeline sequence any significant (abnormal) laboratory or imaging results. Also note if you had none.

List any history of infections (excluding common colds).

List any history of accidents, falls, injuries, concussions in a timeline sequence. Please include Motor Vehicle Accidents.

Describe your family's medical history (mom, dad, grandparents, siblings).

Why do you think health care practitioners have been unsuccessful with your case?

Do you think your conditions can be cured, or improved?

What do you consider a realistic time frame to see changes from us?

What specific improvements in your health would you consider a successful outcome in your case?

Are you willing to change what you believe about health and the body in order to get better and stay better?

Are there any emotional experiences or emotional trauma that could be affecting your health condition?

Additional Questions for Chief Complaint of Pain

If your chief complaint is not a pain complaint, move ahead to Health History Questionnaire.

If your chief complaint is pain, is this injury work related?

☐ Yes ☐ No

If you checked yes to the above question, has your employer been notified?

☐ Yes ☐ No

Can you perform daily home activities?

☐ Yes ☐ No

Is this a Motor Vehicle Accident case (MVA)?

☐ Yes ☐ No

On what date did the accident occur? _____

Health History Questionnaire

Have you ever been diagnosed with/told that you have any of the following? Check N/A if none apply.

- | | | |
|---|--|---|
| ☐ High blood pressure | ☐ Whiplash injury | ☐ Difficulty swallowing |
| ☐ Hardening of the arteries (arteriosclerosis) | ☐ Suffered a stroke | ☐ Dizziness |
| ☐ Diabetes | ☐ You are/were a smoker | ☐ Loss of consciousness, even momentary blackouts |
| ☐ Tuberculosis | ☐ Visual disturbances (blurring, loss, double vision) | ☐ Numbness/Loss of sensation/Loss of strength/Weakness in Face/Fingers/Hands/Arms/Legs or any other part of the body |
| ☐ Cancer | ☐ Hearing disturbances (loss, ringing, other noise) | ☐ Sudden collapse without loss of consciousness |
| ☐ Heart or blood diseases | ☐ Slurred speech or Speech problems | ☐ Not applicable (N/A) |

Systems Review

Check the box for anything you are currently experiencing or have experienced in the past. Leave blank any condition you do not have.

General Symptoms:

- | | | |
|-----------------------------------|---|--------------------------------------|
| ☐ Fever | ☐ Sleep disturbances | ☐ Weight loss |
| ☐ Sweats | ☐ Fatigue | ☐ Weight Gain |
| ☐ Fainting | ☐ Nervousness | |

Neurological:

- | | | |
|--|--------------------------------------|---|
| ☐ Visual Disturbances | ☐ Convulsions | ☐ Neuralgia (nerve pain) |
| ☐ Dizziness | ☐ Headaches | ☐ Poor Coordination |
| ☐ Fainting | ☐ Numbness | ☐ Weakness |

Eyes, Ears, Nose & Throat:

- | | | |
|--|---|--|
| ☐ Eye Pain | ☐ Nosebleeds | ☐ Nasal Drainage |
| ☐ Double Vision | ☐ Trouble Swallowing | ☐ Enlarged Glands |
| ☐ Ringing in the Ears | ☐ Hoarseness | |
| ☐ Deafness | ☐ Sinus Infections | |

Respiratory:

- | | | |
|---|---|---------------------------------|
| ☐ Chronic Cough | ☐ Chest Pain | ☐ Asthma |
| ☐ Spitting up Phlegm | ☐ Wheezing | |
| ☐ Spitting up Blood | ☐ Difficulty Breathing | |

Cardiovascular:

- | | | |
|--|--|--|
| ☐ Rapid Beating Heart | ☐ Pain over the Heart | ☐ Cold Hands, Cold Feet |
| ☐ Slow Beating Heart | ☐ Hardening of the Arteries | ☐ Varicose Veins |
| ☐ High Blood Pressure | ☐ Swollen Ankles | |
| ☐ Low Blood Pressure | ☐ Poor Circulation | |

Muscle & Joint:

- | | | |
|--|--|---|
| ☐ Neck Pain | ☐ Knee Pain | ☐ Spinal Curvature |
| ☐ Low Back Pain | ☐ Foot Pain | ☐ Arthritis |
| ☐ Arm Pain | ☐ Pain/Numbness in Arm/Legs | ☐ Fractures |
| ☐ Shoulder Pain | ☐ Pain between Shoulders | |
| ☐ Leg Pain | ☐ Swollen Joints | |

Genitourinary:

- | | | |
|---|---|--|
| ☐ Frequent Urination | ☐ Puss in Urine | ☐ Uncontrollable Urine Flow |
| ☐ Painful Urination | ☐ Kidney Infection | |
| ☐ Blood in Urine | ☐ Prostate Trouble | |

Gastrointestinal:

- | | | |
|--|---------------------------------------|---|
| ☐ Poor Appetite | ☐ Nausea | ☐ Blood in Stools |
| ☐ Difficult Digestion | ☐ Vomiting | ☐ Gallbladder/Jaundice |
| ☐ Heartburn | ☐ Constipation | ☐ Colitis |
| ☐ Ulcers | ☐ Diarrhea | |

For Women Only:

- | | | |
|---|--|--|
| ☐ Painful Menstruation | ☐ Hot Flashes | ☐ Irregular Cycle |
| ☐ Cramps or Back Pain | ☐ Nipple Discharge | ☐ Lumps in Breasts |
| ☐ Menopausal Symptoms | ☐ Birth Control Pills | ☐ Complication with Pregnancy |
| ☐ Currently Pregnant | ☐ Past C-section | ☐ Vaginal Birth |

Nutritional Screening

Do you have any special dietary restrictions (Vegetarian, Vegan, Paleo, Gluten-free, Dairy-free, FODMAPS ...) or is your diet unrestricted? Please list.

Do you consume Alcohol, Caffeine? Please check if you do and the frequency of each.

☐ Alcohol _____

☐ Caffeine _____

Autoimmunity (have you or a family member been diagnosed with)

- | | | |
|---|---|---|
| ☐ Celiac Disease | ☐ Sjogrens | ☐ Inflammatory Bowel Disease |
| ☐ Diabetes | ☐ Psoriatic Arthritis | ☐ Addison's Disease (adrenal) |
| ☐ Pernicious Anemia | ☐ Multiple Sclerosis | ☐ Myasthenia Gravis |
| ☐ Rheumatoid Arthritis | ☐ Systemic Lupus Erythematosus | ☐ Thyroid problems (Hashimoto's, graves) |

Autoimmunity Symptoms

- | | | |
|---|---|--|
| ☐ Your symptoms keep getting worse over time | ☐ Your symptoms wax and wane (increase/decrease) for unknown reasons | ☐ Numbness and tingling in the hands and feet |
| ☐ Achy muscles | ☐ Swollen Glands | ☐ Low grade fever |
| ☐ Trouble concentrating | ☐ Fatigue | ☐ Hair loss |
| ☐ Diarrhea | ☐ Skin rashes | ☐ Problems losing weight |
| ☐ Red, warm sore joints | ☐ Weakness | ☐ Troubles with balance and walking |
| ☐ Weight loss for unknown reasons | ☐ Fast heart beat | ☐ Heat intolerance |
| ☐ Dry eyes | ☐ Dry mouth | ☐ Weight gain |
| ☐ Sensitivity to heat or cold | ☐ Swelling over throat | ☐ Problems swallowing |
| ☐ Abdominal pain | | |

Iron Deficiency Symptoms

- | | | |
|--|---|---|
| ☐ Chronic Fatigue | ☐ Pronounced lack of energy | ☐ Low exercise tolerance |
| ☐ Thin and fragile finger nails, nails have become pale and changed shape | ☐ Headaches (for women, especially with menstrual cycle) | ☐ Shortness of breath |
| ☐ Heart palpitations | ☐ Restless legs | ☐ Pale skin |
| ☐ Hair loss or hair has become brittle, weak, dull | ☐ Smooth tongue | ☐ Cold hands and feet |
| ☐ Pica: craving to eat ice, dirt, paper or other non-food items | | |

Are you in any of the following risk groups for iron deficiency?

- | | | |
|--|---|---|
| ☐ Have heavy periods | ☐ Stomach or bowel problems | ☐ Use blood thinners |
| ☐ Diagnosed with uterine fibroids | ☐ Frequent blood donor | ☐ Recent surgery |
| ☐ Diet does not contain a lot of red meat | ☐ Athlete | ☐ Vegan/Vegetarian |
| ☐ Chronic kidney disease | ☐ Prior episodes of low iron | ☐ Pregnant |

Dysglycemia

- | | | |
|---|--|---|
| ☐ Tired shortly after eating | ☐ Increased thirst | ☐ Shakiness |
| ☐ Frequently need to pee | ☐ Dry mouth | ☐ Anxiety |
| ☐ Frequently headaches | ☐ Nausea, vomiting | ☐ Heart palpitations |
| ☐ Have a hard time losing weight | ☐ Irritable or angry if you haven't eaten | |

Hypothalamic Pituitary Axis

- | | | |
|---|--|---|
| ☐ Difficulty getting up in the morning | ☐ Frequent colds/sicknesses | ☐ Dizziness |
| ☐ Tiredness not relieved by sleep | ☐ Fat accumulates around the abdominals | ☐ Dry skin |
| ☐ Insomnia | ☐ Brain fog | ☐ Low libido |
| ☐ Thyroid problems | ☐ Slow wound healing | ☐ Poor muscle tone |
| ☐ Poor circulation | ☐ Craving salty/sweet | ☐ Depression/anxiety |

Lifestyle

Describe your level of stress ☐ None ☐ Mild ☐ Moderate ☐ Severe

What contributes the most to your stress (if you have any)

☐ Work ☐ World Events ☐ Family ☐ Health Conditions ☐ Finances ☐ Other

What do you do to manage your stress? Please list the frequency (e.g. I walk 3x/week).

Do you exercise? ☐ Daily ☐ Occasionally ☐ Not at all

What kinds of exercise do you do? Please list.

Do you meditate or have mindfulness practices? ☐ Yes ☐ No

Consents

Accuracy of Information

☐ I certify that the above information is correct to my knowledge

Signature: _____ Date: _____