**Blue Tree Nutrition, LLC**

*Valerie Polley, RDN, CDN*

**Nutrition Health Questionnaire**

*The following information is confidential and will not be revealed to anyone outside Blue Tree Nutrition, LLC without your written consent.*

**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: \_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_ Weight loss or gain: \_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_M \_\_\_\_\_F

**Have you been diagnosed with irritable bowel syndrome?**

\_\_\_\_\_Yes \_\_\_\_\_No

**Have you been diagnosed with small intestinal bacterial overgrowth?**

\_\_\_\_\_Yes \_\_\_\_\_No

**Have you been diagnosed with celiac disease?**

\_\_\_\_\_Yes \_\_\_\_\_No

**Have you been diagnosed with inflammatory bowel disease?**

\_\_\_\_\_Yes \_\_\_\_\_No

**Do you have a history of foodborne illness?**

\_\_\_\_\_Yes \_\_\_\_\_No

**Testing**

**Please check any of the following for which you have been tested and note any abnormal results:**

\_\_\_\_\_Celiac Testing (\_\_\_\_\_biopsy/\_\_\_\_\_blood test):

\_\_\_\_\_Lactose intolerance breath test:

\_\_\_\_\_Fructose malabsorption breath test:

\_\_\_\_\_Sucrase-Isomaltase deficiency breath test:

\_\_\_\_\_Small intestinal bacterial overgrowth breath test:

 \_\_\_\_\_Methane tested \_\_\_\_\_ Hydrogen tested \_\_\_\_\_Unsure

\_\_\_\_\_Thyroid labs:

\_\_\_\_\_Vitamin D:

\_\_\_\_\_Allergy testing:

 What type? \_\_\_\_\_IgE \_\_\_\_\_IgG

**GI Procedures**

**Please check any procedures you have completed and any abnormal results:**

\_\_\_\_\_Colonoscopy:

\_\_\_\_\_Endoscopy:

\_\_\_\_\_Gastric emptying study:

\_\_\_\_\_Upper GI X-Ray:

\_\_\_\_\_Anal manometry

**Symptoms**

On a scale of 1-4 (4=terrible, 0=non-existent) please circle a number that identifies the level of discomfort of the following symptoms:

**Gastrointestinal Symptoms**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Gas | 0 | 1 | 2 | 3 | 4 |
| Bloating | 0 | 1 | 2 | 3 | 4 |
| Nausea | 0 | 1 | 2 | 3 | 4 |
| Diarrhea | 0 | 1 | 2 | 3 | 4 |
| Constipation | 0 | 1 | 2 | 3 | 4 |
| Abdominal Pain | 0 | 1 | 2 | 3 | 4 |
| Incomplete Emptying | 0 | 1 | 2 | 3 | 4 |
| Early Satiety | 0 | 1 | 2 | 3 | 4 |
| Reflux/GERD | 0 | 1 | 2 | 3 | 4 |

**Systemic Symptoms**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Body Aches | 0 | 1 | 2 | 3 | 4 |
| Joint Pain | 0 | 1 | 2 | 3 | 4 |
| Sleep Disturbance | 0 | 1 | 2 | 3 | 4 |
| Fatigue | 0 | 1 | 2 | 3 | 4 |
| Headaches | 0 | 1 | 2 | 3 | 4 |
| Anxiety | 0 | 1 | 2 | 3 | 4 |
| Dry Eyes | 0 | 1 | 2 | 3 | 4 |
| Atopic Dermatitis | 0 | 1 | 2 | 3 | 4 |
| Itchy Skin | 0 | 1 | 2 | 3 | 4 |
| Hives (Uticaria) | 0 | 1 | 2 | 3 | 4 |

***Based on the above symptoms, how frequently during the week or month do your symptoms impact the quality of your life?***

**Medical History**

*Please list any other relevant medical history, age of onset and if there is any explanation needed.*

|  |  |  |
| --- | --- | --- |
| *Condition* | *Age of Onset* | *Explanation if Needed* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Relevant Family Medical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medications**

*Please list medications you are currently taking, dosage per day, and the reason for taking them.*

|  |  |  |
| --- | --- | --- |
| *Medication* | *Dosage per Day* | *Reason for Taking* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Check below if you are taking any of the following and mark dosage:**

|  |  |
| --- | --- |
| *Supplement/Brand* | *Dosage per Day* |
| \_\_\_\_\_Peppermint Oil |  |
| \_\_\_\_\_Iberogast or IBgard |  |
| \_\_\_\_\_Vitamin D  |  |
| \_\_\_\_\_Calcium (List type, such as carbonate, etc.) |  |
| \_\_\_\_\_Iron |  |
| \_\_\_\_\_Fiber Supplements |  |
| \_\_\_\_\_Laxative |  |
| \_\_\_\_\_Probiotic |  |
| \_\_\_\_\_Multivitamin |  |

**Vitamins, Minerals, Supplements not listed above.**

*Please list any supplements, the dosage per day, and the reason for taking them.*

|  |  |  |
| --- | --- | --- |
| *Supplement/Brand* | *Dosage per Day* | *Reason for Taking* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Daily eating pattern**

*Below please list what you frequently eat as a meal or snack. If you do not eat a meal or snack listed, please leave it blank.*

|  |  |
| --- | --- |
| ***Meal*** | ***Food Consumed*** |
| Breakfast |  |
| Snack |  |
| Lunch |  |
| Snack |  |
| Dinner |  |
| Snack |  |

**Do you drink caffeinated beverages such as teas, coffee and soda?**

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you drink alcohol?**

If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How often do you eat out?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Which restaurants do you choose most frequently?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who does the grocery shopping/prepares meals?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you are on a gluten free diet, is your kitchen completely gluten-free or do other family members still eat gluten?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Eating Questions**

**1**. Do you struggle finding foods to eat? \_\_\_\_\_Yes \_\_\_\_\_No

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**. Have you ever been diagnosed with an eating disorder? \_\_\_\_\_Yes \_\_\_\_\_No

 If yes, is this still an active issue for you? \_\_\_\_\_Yes \_\_\_\_\_No

 Are you in treatment? \_\_\_\_\_Yes \_\_\_\_\_No

**3**. Do you spend much of your day thinking about food, food related decisions or meal planning? \_\_\_\_\_Yes \_\_\_\_\_No

**4.** Do you have fears or guilt associated with eating certain foods? \_\_\_\_\_Yes \_\_\_\_\_No

**Exercise and Physical Activity**

*Over the past 6-12 months, please describe your typical exercise routine.*

|  |  |  |
| --- | --- | --- |
| *Type of Exercise* | *Frequency (days per week)* | *Duration (how long per day)* |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

What are your primary goals for your nutrition consultation?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*To the best of my knowledge, the information I have provided is accurate. I will agree to inform Valerie Polley, RDN, CDN of any changes in my health status.*

Client Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent or Legal Guardian:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

(If client under 18 years of age)

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