LIVE WELL
NUTRITION

Health Questionnaire

Name:_____ Today's Date:_____
Address:_____
City:_____ State:_____Zip:_____
Email address:_____ Skype contact (if applicable):_____
Home Phone:_____ Work Phone:_____ Cell Phone:_____
What numbers are best for detailed messages?_____
What is your preferred method of contact? _____
How did you find out about Leslie Weinman? _____
☐ Male ☐ Female DOB:_____ Place of Birth:_____

What would you like help with at this time?

Please list your health concerns: **How long have you had these conditions?**

1._____ _____
2._____ _____
3._____ _____
4._____ _____
5._____ _____

Name and contact information for Primary Physician: _____
_____

Please list other practitioners that you are seeing:_____
_____

Family History:

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother	Deceased	
Paternal Grandfather	Deceased	
Maternal Grandmother	Deceased	
Maternal Grandfather	Deceased	
Father	Deceased	
Mother	Deceased	
Brothers	Deceased	
Sisters	Deceased	
Children	Deceased	

Comments on family health history: _____

_____

Medications and Supplement *Please list all* ***prescription medications*** *and* ***nutritional supplements, herbs*** *you are currently taking. Use a separate sheet if needed.*

Medications	**Name**	**Dosage**	**Frequency**	**Length of time**	**Purpose**

Supplements	**Name**	**Dosage**	**Frequency**	**Length of time**	**Purpose**

Blood Pressure:_____

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, tylenol, antibiotics, etc)? _____

_____

List major traumas, major or minor surgeries, and hospitalizations? _____

_____

_____

Physical Activity and Lifestyle

What kind of physical activities do you do? _____

Are you satisfied with your energy level? _____

Are there any problems/limitations that inhibit your physical activity? _____

Activity	**Type(s)**	**Days per week**	**Duration**
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

What do you do for relaxation? _____
How many hours of sleep do you get a night/day? _____ Do you sleep well? _____

Relationship Status: _____ # of times Married:_____ Divorced:_____ Widowed:_____
Current Occupation:_____ How many years? _____ Hours per week?_____
Do you like your work? _____
Passions/Interests? _____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your
Work: _____ Current health status: _____ Social/family situation:_____ Life in general:_____
What do you believe you can do to make a difference in your current health? _____
_____

Environmental information: How often are you exposed to any of the following?
*Insert a number and circle **day** or **week***

Cigarette smoke: 7 x d / wk	How many mercury amalgams do you have? 7
Wood stove 7 x d / wk	Recreational drugs 7 x d / wk
Perfumes/hair dyes: 7 x d / wk	Pet dander 7 x d / wk
Car exhaust: 7 x d / wk	Mold 7 x d / wk
Pesticides: 7 x d / wk	Cleaning products 7 x d / wk
Dry cleaned clothes 7 x d / wk	Teflon or aluminum pans 7 x d / wk
Bottled water 7 x d / wk	Photo developing/harsh chemicals: 7 x d / wk

Nutrition

Have you ever had a nutritional consult?_____
Please list **food** allergies: _____
Please list **non-food** and **environmental** allergies: _____
Please list any special dietary restrictions/habits you have: _____
_____
What foods do you crave if anything? _____
What are your favorite foods? _____
Where do you grocery shop? _____

Please describe any changes you have made to your diet to improve your health? _____
_____
How would you describe your relationship to food? _____
_____
Height:_____ Weight: _____ Ideal Weight: _____
Highest Adult weight: _____ Year: _____ Lowest Adult Weight: _____ Year: _____

Food Frequency: How often do you eat or do the following? *Insert a number and circle **day** or **week***

Meals per day: _____

Snacks per day: _____

Water _____ ounces per day

Prepare meals: _____ x d / wk

Nuts/Seeds: _____ x d / wk

Lentils/Beans: _____ x d / wk

Yogurt: _____ x d / wk

Fats and oils: _____ x d / wk *What kinds?*_____

Dairy Milk/Cheese: _____x d / wk

Other Milk: _____ x d / wk

Bread: _____ x d / wk

Whole Grains: _____ x d / wk

Pasta: _____ x d / wk

Chips/crackers etc.: _____ x d / wk

Candy: _____ x d / wk

Fast Food: _____ x d / wk

Red Meat: _____ x d / wk

Chicken/Turkey: _____ x d / wk

Deli Meat: _____ x d / wk

Fish: _____ x d / wk

Shellfish: _____ x d / wk

Organ meat: _____ x d / wk

Soy products _____ x d / wk

Eggs: _____ x d / wk

ALL VEGGIES: _____ x d / wk

ALL FRUIT: _____ x d / wk

Coffee: _____ x d / wk, decaf? _____

Herb or other Tea: _____ x d / wk

Soft Drinks: _____ x d / wk, diet OR regular

Frozen Dinners: _____ x d / wk

Alcoholic Drinks: _____ x d / wk

Eat fast or on the run: _____ x d / wk

NUTRITION: 3-Day Food Diary

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior, the purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack

Symptom Review: Please check symptoms noticed in the past year. Any major problems that you had previously, but no longer have, mark with a "P"

UPPER GI	___	Sometimes nausea in evenings	___	Sometimes nausea in mornings
	___	Indigestion after eating	___	Sometimes excess salivation
	___	Duodenal ulcer	___	Stomach ulcer
	___	Sometimes foul burps	___	Strong, demanding hunger
	___	Butterflies in stomach		
	___	Seldom eat breakfast		
	___	Often don't' finish meals		
	___	Often eat to calm down		
	___	Frequent use of alcohol		
	___	Frequent poor appetite		
	___	Bitter taste or bad breath in morning		
	___	Acid indigestion at night		
	___	Frequent mouth or cold sores, or receding gums		
	___	Mouth frequently too dry, or difficulty swallowing		

LOWER GI	___	Tongue often coated	___	Stools loose with gas
	___	Frequent constipation, need for laxatives	___	Digestion unusually rapid
	___	Light colored, hard stools	___	Loose stools when tired/stressed
	___	Intestines often bloated, or gassy	___	Dark, soft stools
	___	Constipation with hemorrhoids or pain	___	Quick defecation after eating
	___	Constipation with hard, marbly stools		
	___	Alternating constipation / diarrhea		

LIVER	___	Dry, even scaly skin	___	Moist, sometimes oily skin
	___	Hay fever or asthma	___	Hives from food or drugs
	___	Craves fruit or sweet	___	Craves protein, fats
	___	Frequent trouble digesting fats	___	Fever with sweat when sick
	___	Acne on face AND buttocks		
	___	Seem to have low blood sugar		
	___	Had hepatitis in past		
	___	Frequent use of alcohol or chemicals/solvents		
	___	Psoriasis, eczema, dermatitis		
	___	Frequent minor illnesses, don't sweat		

RENAL & URINARY	___	Standing quickly causes faintness or dizziness	___	Standing quickly makes pulse roar in ears
	___	Frequent flushing or blushing	___	Frequent water retention
	___	Moderate low blood pressure	___	Urine usually dark
	___	Frequent thirst	___	Moderate high blood pressure
	___	Craving for salt	___	Infrequent urination, copious urine
	___	Urine always light colored		
	___	Dull ache or dribble after urination		
	___	Frequent bladder infections		
	___	Frequent or urgent urination, small amounts		
	___	Mucus in urine		

CV & LYMPH	___	Fast, light pulse	___	Slow, strong pulse
	___	Cold bodied	___	Frequent physical activity
	___	Sometime dizzy or faint	___	Warm bodied
	___	Hands cold, clammy or dry	___	Hands warm, sweaty
	___	Hypertension, not responding to diuretics	___	Palpitations as an adolescent or before menses
	___	Injuries/Colds heal slowly	___	Hypertension, responds to diuretics
	___	Cold hands and feet	___	Injuries/Colds heal quickly

MALE REPRO	___	Difficult maintaining erection when you feel in the mood
	___	Benign prostatic hypertrophy
	___	Pain or ache after orgasm
	Are you sexually active? _____	

FEMALE REPRO	__	Cycle more than 28 days	___	Cycle less than 28 days
	__	Miss some periods	___	Water retention before menses
	__	Menses slow starting with cramps	___	Constipation before, loose stools after menses start
	__	Menstruation always lengthy	___	Always hungry before menses
	__	Abnormal Pap Smear	___	Breast tender before menses
	__	History of PID, cervicitis	___	Palpitations before menses
	__	Miscarriages, problem pregnancy	___	**Number of Children/Live Births**
	__	Tried, couldn't take birth control pills	___	**Any chance you may be or may try to get pregnant**
	Date of Last Menses_____ Are you sexually active? _____Birth Control Method _____			

MUCUS & SKIN	___	Dry scalp or hair	___	Oily scalp or hair
	___	Lips often dry and chapped	___	Sweat freely with strong scent
		Sores, cracks, fissures in mouth, vagina or anus		
	___	Food causes distress as it passes through	___	Oily skin, facial acne
	___	Skin eruptions are deep, not coming to a head		
	___	Cracks, fissures on heel, elbow, feet, poorly healing		

GENERAL	**Mark "1" if somewhat applies. Mark "2" if strongly applies.**			
	__	Aluminum cooking vessels	__	Increase in weight (recent)
	__	Awakens, can't go back to sleep	__	Lack of sensation somewhere
	__	Bad dreams	__	Likes depressants
	__	Blurred vision	__	Likes stimulants
	__	Brown spots, bronzing of skin	__	Lower back pain
	__	Bruises easily	__	Muscle cramps
	__	Can't gain weight	__	Nails split, brittle
	__	Can't lose weight	__	Nails weak, ridges
	__	Can't get started without coffee	__	Nosebleeds frequently
	__	Chemical or spray poisoning	__	Pollution heavy in environment
	__	Chronic fatigue, depression	__	Ringing in ears
	__	Cry easily without seeming cause	__	Pulse speeds up after meals
	__	Depressed for long periods	__	Sensitive to cold weather
	__	Earaches	__	Sensitive to hot weather
	__	Eat often or else faint/nervous	__	Sensitive to high humidity
	__	Eyes often red or inflamed	__	Sensitive to low humidity
	__	Face, eyes get puffy	__	Sexual desire decreased
	__	Facial twitches	__	Sexual desire increased
	__	Gum problems	__	Stuffy nose during the day
	__	Headaches	__	Stuffy nose in evening or night
	__	Headaches in morning, wearing off	__	Tendency to anemia
	__	Heart palpitations after eating	__	Tremors in hands or neck
	__	Highly emotional	__	Varicose veins
	__	Highly controlled	__	Weight gain in upper arms, shoulders, back of neck
	__	Impaired hearing		

RESPIRATORY	___	Shortness of breath when standing or walking	___	Easy coughing of mucus
	___	Tobacco smoker	___	Sometimes hyperventilates
	___	Difficulty swallowing		
	___	Difficulty coughing up mucus		
	___	Rapid, shallow breather		
	___	Sometimes wake up choking or gasping for breath		
	___	Yawns frequently		
	___	Frequent chest colds		

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