Nutrition Works Educational Services, Inc.

Please take the time to fill out this questionnaire to the best of your ability, so we may better serve you.
Thank you.

Health Questionnaire

Name:	Today's Date:
Street Address:	Date of Birth:
City, State, Zip Code:	Age:
Home Number:	Blood Type: **A B AB O**
Cell Number:	
Work Number:	Are you employed by, affiliated with or a member of any type of government agency? **YES NO**
Preferred number to reach you: **HOME CELL WORK**	Medical Doctor:
Can we leave a detailed message? **YES NO** If yes, which number? **HOME CELL WORK**	How did you hear about us?
Email Address:	Were you referred? **YES NO** If yes, by whom?

Emergency Contact

Name:	Relationship:	Phone Number:

Occupation and Interests

Occupation:	How long?	Are you satisfied? (1-10)
What are your interests?		

Demographics

Height:	Highest Adult Height: Age:	
Weight:	Lowest Adult Weight: Age:	Highest Adult Weight: Age:

Are you comfortable with taking Homeopathics? **YES** **NO**

What are your primary reasons for coming to Nutrition Works?

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Medical Information

What health concerns did you experience as a child?

What health concerns have you experienced as an adult?

List of Current Medications (Over-the-Counter and Prescription)

Name	Dosage	Frequency	Reason for Taking

List of Current Supplements

Name	Dosage	Frequency	Reason for Taking

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Do you have any allergies, whether to medications, seasonal, or to foods/products?

Surgeries

Type of Surgery	Date	Age	Comments

Insurance

Do you have Health Insurance? **YES** **NO**

Are you affiliated with any type of Medicare or Medicaid? **YES** **NO**

(Even if it is a secondary insurance, we need to be aware of it. Thank you.)

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Your Chief Complaints

Please mark the principal or major conditions which you are concerned about, would like eliminated, or desire treatment for.

( ) Overweight
( ) Underweight
( ) Menopause Problems
( ) Sexual Problems
( ) Heart Condition
( ) Blood Pressure
( ) Digestion Trouble
( ) Stomach/Gall Bladder Problems
( ) Intestinal Problems
( ) Diabetes Mellitus
( ) Skin Disorders
( ) Sinus Infections/Allergies in General
( ) Allergies to Foods
( ) Nervous/Emotional Trouble
( ) Thorough Diagnostic Checkup

( ) Nutritional Evaluation
( ) Arthritis/Rhuematism
( ) Headaches
( ) Female/Male Problems
( ) Extreme Fatigue
( ) Cancer
( ) Circulation Problems
( ) Lung and/or Breathing Problems
( ) Neck or Spine Problems
( ) Ear or Hearing Disorder
( ) Nose/Throat/Mouth Problems
( ) Eye Problems
( ) Dizziness/Balance Disorder
( ) Kidney/Bladder/Urinary Problems
( ) Alcohol or Tobacco Addiction

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Patient Diagnostic Questionnaire

Please mark if you have experienced any of the symptoms in the last 5 years.

Neuromuscular

( ) Do you experience neck pain?
( ) Do you experience pain in between the shoulders?
( ) Do you suffer from low back pain?
( ) Do you experience swollen joints?
( ) Do you have a spinal curvature?
( ) Do you suffer from muscle spasms?
( ) Are your muscles frequently sore?
( ) Do you experience muscle weakness?
( ) Are your joints stiff in the morning?
( ) Do you experience shoulder/arm pain?
( ) Do you suffer from leg pain at rest?
( ) Do you have rheumatism?
( ) Does any part of your body experience numbness/tingling? If so where?

_____

( ) Do you experience frequent headaches?
( ) Are you often dizzy?
( ) Do you frequently feel faint?
( ) Do you have epilepsy?
( ) Do you bite your nails badly?
( ) Do you stutter or stammer?
( ) Are you a sleep walker?
( ) Do you suffer from motion sickness?

Feet

( ) Do you suffer from painful feet?
( ) Do you experience frequent foot cramps?
( ) Do you have plantar warts?
( ) Do you have heel spurs?
( ) Are you troubled with corns?

Skin

( ) Is your skin tender?
( ) Does your skin itch?
( ) Do you have skin eruptions?
( ) Is you skin rough, especially on the back of your arms?
( ) Do you have Psoriasis?
( ) Do you bruise easily?
( ) Do you have acne?
( ) Are you troubled with boils?
( ) Do you have Eczema?
( ) Are you aware of moles which are changing in size or color?
( ) Do you experience goose bumps?
( ) Do you experience hives (allergic reaction of the skin)?
( ) Do you experience excessive perspiration?
( ) Do you get sores that are slow to heal?

Urinary

( ) Do you experience frequent urination?
( ) Do you awaken at night to urinate?
( ) Are you a bed wetter?
( ) Do you dribble when sneezing or laughing?
( ) Have you ever lost control of your bladder?
( ) Do you experience painful urination?
( ) Do you experience blood in your urine?
( ) Are you troubled by urgent urination?
( ) Do you have difficulty in starting the stream?
( ) Do you experience frequent bladder infections?
( ) Do you experience frequent kidney infections?
( ) Do you experience kidney stones?

Endocrine

( ) Do you experience excessive thirst?
( ) Do you frequently feel cold?
( ) Do you frequently feel hot?
( ) Are you unusually tired most of the time?
( ) Are you unusually nervous or jumpy?
( ) Is your hair coarse?
( ) Is your skin Coarse?
( ) Are you diabetic?
( ) Do you get lightheaded when standing quickly?

Mouth and Throat

( ) Is your tongue badly coated?
( ) Do you have bad breath?
( ) Do you suffer from sores or cracks at the corners of mouth?
( ) Do you frequently experience canker sores?
( ) Are your gums sore?
( ) Do you frequently suffer from fever blisters?
( ) Do your gums bleed when you brush your teeth?
( ) Do you experience sore throats frequently?
( ) Are your glands often swollen?
( ) Do you suffer from toothaches?
( ) Is your mouth dry?
( ) Do you have excessive saliva?
( ) In the mornings, do you have a bitter taste in

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Patient Diagnostic Questionnaire

Please mark if you have experienced any of the symptoms in the last 5 years.

. your mouth?
( ) Do you frequently have a sore tongue?

Respiratory

( ) Do you experience frequent colds?
( ) Do you suffer from nasal polyps?
( ) Do you often get sinus infections?
( ) Do you experience night sweats?
( ) Do you have hay fever?
( ) Do you wheeze?
( ) Do you have Asthma?
( ) Do you experience difficulty breathing?
( ) Do you have a chronic cough?
( ) Do you spit up phlegm?
( ) Do you spit up blood?
( ) Do you have spells of sneezing?
( ) Is your nose frequently stuffy?
( ) Does your nose run constantly?
( ) Do you have frequent nose bleeds?
( ) Do you catch severe colds?
( ) Do you have a chronic chest condition?
( ) Do you have post nasal drip?

Cardiovascular

( ) Do you have high blood pressure?
( ) Do you have low blood pressure?
( ) Do you have pains in the heart or chest?
( ) Are you troubled with blood clots?
( ) Do you have cold hands?
( ) Are your feet frequently cold?
( ) Do you have varicose veins?
( ) Are your ankles frequently swollen?
( ) Do you have an usually slow pulse rate?
( ) Do you experience spells of rapid heart beat?
( ) Are you aware of your heart skipping beats?
( ) Do you experience shortness of breath while sitting still?
( ) Do you suffer from leg cramps after retiring to bed?
( ) Do you suffer from leg cramps during the day?
( ) Do you experience pain in your leg/hip while walking?

Gastrointestinal

( ) Is your appetite poor?
( ) Do you experience excessive hunger?
( ) Do you experience fainting spells when hungry?

( ) Does eating relieve fatigue?
( ) Do you feel shaky when hungry?
( ) Are you frequently drowsy after eating a meal?
( ) Do you eat when nervous?
( ) Do you have difficulty swallowing?
( ) Do you vomit frequently?
( ) Are you frequently nauseated?
( ) Are you bloated after eating?
( ) Do you experience abdominal gas?
( ) Does eating greasy foods cause you to have indigestion?
( ) Do you belch or burp after eating?
( ) Do you have indigestion immediately upon eating?
    ( ) Indigestion within 1 hour after meals?
    ( ) Indigestion within 2 hours or more after meals?
( ) Do you have loose bowel movements?
( ) Have you ever had intestinal worms?
( ) Do you have pale or yellow colored stools?
( ) Do you have one or less bowel movements daily?
( ) Are your stools bloody?

For Women Only

( ) Do you have painful periods?
( ) Do you have an excessive flow?
( ) Do you have irregular cycles?
( ) Do you suffer from menstrual cramps?
( ) Do you have hot flashes?
( ) Do you have vaginal discharge?
( ) Have you had a hysterectomy?
( ) Do you retain fluid during your periods?
( ) Have you ever miscarried?
( ) Do you have Acne worse at menstruation?
( ) Do you experience tender breasts?
( ) Do you have frequent yeast infections?
( ) Do you have lumps in your breasts?

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Patient Diagnostic Questionnaire

Please mark if you have experienced any of the symptoms in the last 5 years.

( ) Do you have heavy hair growth on face or body?
( ) Do you take birth control pills?
( ) Do you experience pre-menstrual depression?
( ) Is intercourse painful for you?
( ) Do you have diminished sex desire?
( ) Do you have poor or infrequent orgasms?

For Men Only

( ) Do you experience painful genitals?
( ) Do you have prostate troubles?
( ) Do you experience a discharge from the urethra?
( ) Do you have lumps in your testicles?
( ) Do you have sores on external genitalia?
( ) Do you experience difficulty getting or keeping an erection?
( ) Do you have difficulty completing intercourse?
( ) Have you had difficulty fathering children?

Behavioral

( ) Do you experience difficulty falling asleep?
( ) Do you experience difficulty staying asleep?
( ) Do you have recurrent bad dreams?
( ) Do you have difficulty in concentration?
( ) Is your memory poor?
( ) Do strange people or places make you afraid?
( ) Are you scared to be alone?
( ) Do you always need someone to advise you?
( ) Are you afraid to eat anywhere except at home?
( ) Are you unhappy when others are happy?
( ) Are you usually unhappy and depressed?
( ) Do you cry often?
( ) Are you frequently miserable or blue?
( ) Do you sometimes wish you were dead and away from it all?
( ) Are you feelings easily hurt?
( ) Does criticism always upset you?
( ) Do you have to be on guard even with your friends?
( ) Do people usually misunderstand you?
( ) Do people often annoy you?
( ) Are you easily angered?
( ) Do you frequently become scared for no reason?
( ) Do you feel you are under considerable emotional stress?