Nutrition Assessment Questionnaire

by Faye Elahi (214) 437-1297

Name (Adult/ Child's Name)_____Gender_____
Adress_____City _____ State _____ Zip _____
Phone _____ Age _____ Ht._____ Wt. _____
Primary Diagnosis _____Diagnosed By _____
Mothers name (wife's) _____ Profession_____
Fathers name (husband's)_____ Profession _____

This questionnaire is designed solely as an information gathering tool in that it will tell the truth about your body's current state of health. As such, this is not a diagnostic test to determine diseases or how to treat them.

Section 1	Yes	No
1. Do you catch cold easily?	___	___
2. Do you have predisposition to infections of the throat and lungs?	___	
3. Do you have frequent infections of the bladder or the urinary tract?	___	
4. Do you suffer from sinusitis?	___	
5. Do you often have abscesses on the ears?	___	
6. Do you see poorly in dim light?	___	
7. Do you have rough, scaly skin?	___	
8. Do your eyelids become swollen and pus laden?	___	
9. Do you notice poor bone development?	___	
10. Have you had rickets (bowlegs, knock-knees, bone enlargement?)	___	
11. Have you been diagnosed with Osteomalacia?	___	___
12. Have you been diagnosed with Arthritis?	___	
13. How many cavities do you have?	___	
14. Does your blood clot slowly?	___	
15. Do you have pink spots on skin?	___	
16. Do you have ruptured blood vessels in either eye?	___	___
17. Do you have inflamed gums?	___	___
18. Do you have fleeting joint pains?	___	___
19. Do you have abnormal hair loss?	___	___
27. Do you have cracks or sores in the corners of your mouth?	___	___
28. Is your tongue red-purple color?	___	___
29. Is your tongue shiny?	___	___
30. Are your eyes sensitive to light?	___	___
31. Do your eyes get tired easily?	___	___
32. Do your eyes burn or itch often?	___	___
33. Do you have many red lines in the white of your eyes?	___	___
34. Do you have significant oiliness around the corner of your nose?	___	___
35. Do you suffer from chronic inflammation of the skin?	___	___
36. Do you have a healthy appetite?	___	___
37. Do you have frequent indigestion or diarrhea?	___	___
38. Do your hands and feet often feel hot?	___	___
39. Do you often feel dizzy?	___	___
40. Do you often feel nauseous?	___	___
41. Do you have/had kidney stones?	___	___
42. Do you have edema?	___	___
43. Have you ever observed a greenish tint to your urine?	___	___
44. Is your tongue sore?	___	___
45. Have you noticed you hands and/or feet tingle?	___	___
46. Do you have jerking of limbs?	___	___
47. Do you have chronic headaches?	___	___
48. Do you suddenly feel dizzy? (the room turns around)	___	___
49. Does your heart beat fast when you move around hard?	___	___
50. Has the doctor diagnosed your child as hypoglycemic?	___	___

	Yes	No
20. Do your gums bleed when you brush?		
21. Do you have cartilage problems?		
22. Do you have a lot of colds?		
23. Do you have an enlarged heart?		
24. Is your diastolic pressure > 90?		
25. Do you notice being "weak"?		
26. Do you have many fears?		
27.		
28. Do you suffer from allergies?		
If yes, what kind?		
51. Are you chronically constipated?		
52. Do you have skin inflammation?		
53. Do you suffer from insomnia?		
54. Do you have poor appetite?		
If yes, name the foods you prefer to eat.		
55. Do you sometimes feel like throwing up?		
56. Do you suffer from eczema?		
57. Has your doctor diagnosed you with Atherosclerosis?		
58. Do you have high cholesterol?		
59. Do you have high blood pressure?		
60. Do you have a problem losing weight?		
61. Have you been diagnosed with weak muscle or myasthenia gravis?		
62. Do you have macrocytic anemia?		
63. Are you chronically fatigued?		
64. Do you have indigestion 2-4 hours after eating?		
65. Do you have a heavy, full, loggy feeling after eating a heavy meal?		
66. Do you have periods of constipation alternating with diarrhea?		
67. Do you prefer to eat dairy, veggies, meats, fruits or starches? (circle your choices above)		
68. Do you have stomach bloatedness after drinking milk?		
69. Do you have tooth enamel defects?		
70. Do you often have leg cramps?		
71. Are you hyperactive or irritable?		
72. Are you prone to tooth decay?		
73. Are your teeth crowded, with poor placement in the mouth?		
74. Do you have swelling of the ankles and hands?		
75. Do you often feel weak muscles?		
76. Do you have diabetic tendencies?		

	Yes	No
77. Do your suffer from Dehydration? (dry tongue, shrunken, loose skin)?		
79. Do you feel exhausted even in early morning hours ?		
80. Do you have poor concentration or do you finish the task?		
81. Are you easily frustrated?		
82. Do you get fussy often? If yes, when? a.m. p.m. or both?		
83. Are you naturally excited after eating a certain snack or meal?		
If yes, what foods or snacks seem to make you feel excited?_____		

Q. 84-90 are for children only

84. Do you have speech impairements?		
85. Does your child verbalize his/her needs or does he/she scream or tantrum to make a need known? (ignore if adult)		
86. If your child is verbal, and he/she does scream for no apparent reason, how long after eating a food does he/she scream?(ignore)		
87. Are you physically aggressive? (SIB, hurting others, hurting things)?		
88. If yes, is there a noticeable pattern to when you are most likely to show physical aggression?		
89. Do you follow instructions easily ?		

If not, what is the problem in following instructions ?_____

Please write a one day diet sample with food type and serving size:
When completed, please call Faye Elahi's office to set up an appointment.
Day/ Date:_____

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Please List all subscription medication you/ your child is on with dosage

Med name	Dosage	Prescribed for: