LIFE DESIGN nutrition

Health Evaluation

PART ONE: GENERAL INFORMATION

Name_____Age _____

Address_____ (city) _____(state) _____(zip code) _____

Phone (home)_____ (cell) _____ (work) _____(fax)_____

Email address _____

Referred by_____

Height _____Weight_____ (% body fat) _____ Date of Birth_____

Do you currently take vitamins or other supplements: _____no _____yes If yes, please list _____

_____

Have you had anything to eat in the past three hours? _____no _____yes If yes, what did you eat? _____

_____

What is your reason for seeking help? _____

Have you worked with any other nutritionist or person who supplies you with supplements? If so, who and when? _____

_____

PART TWO: MEDICATIONS

Check any of your following conditions or medications you are currently taking:

____ Antacids
____ Antidepressants
____ Antibiotics
____ Anti-inflammatory medications
____ High blood pressure medications
____ Pain medications
_____Water retention
_____ Heart Medications
_____ Hormones
_____ Oral contraceptives
_____ Radiation/Chemotherapy
_____ Ulcer medications
_____Steroids
_____ Laxatives
_____Thyroid meds
_____Other (list)
_____
_____

The following information being sought is of a nutritional nature and not a medical diagnosis, treatment, disease prevention or health assessment. Any suggestion is provided to augment the quality of foods delivered through the diet.

PART TWO: SYMPTOMATIC SELF-EVALUATION

Each of the following sections contains questions regarding your evaluation of conditions that may be affecting your health and personal well-being. Circle the number in each column that describes your situation. Leave questions blank that you are not sure of. For questions with only a "No" or "Yes", use column 1 for "No" and column 2 for "Yes".

Section 1

Please list the foods you ate yesterday and what you eat for a normal diet.

Foods you ate yesterday
Breakfast_____
Lunch_____
Dinner _____
Snacks_____

Your normal diet
Breakfast_____
Lunch_____
Dinner _____
Snacks_____

How often do you do strength training? _____

How often do you do aerobics? _____

Section 2

Lifestyle Choices	No	Yes	Often
1. Do you eat cooked and processed foods?	0	1	2
2. Do you eat rapidly, without chewing thorougly?	0	1	2
3. Do you eat until you feel full?	0	1	2
4. Do you drink carbonated beverages?	0	1	2
5. Do you drink coffee and tea?	0	1	2
6. Do you drink alcoholic beverages?	0	1	2
Symptoms			
7. Do you experience bloating?	0	1	2
8. Do you feel too full after eating?	0	1	2
9. Do you feel sleepy after eating?	0	1	2
10. Do you have uncomfortable or adverse reactions after eating (gas,heartburn, etc.)?	0	1	2
11. Do you feel a need to eliminate too soon after eating?	0	1	2
12. Do you have diarrhea after eating?	0	1	2
13. Do you feel flush after eating?	0	1	2

Section 2: continued

	No	Yes	Often
14. Do you have difficulty breathing after eating?	0	1	2
15. Does your food pass through undigested?	0	1	2
16. Do you get indigestion after eating?	0	1	2

Total: _____

Section 3:

Lifestyle Choices

1. Do you live or work where there is air pollution?	0	1	2
2. Do you work on a computer?	0	1	2
3. Do you use TVs and/or microwave ovens?	0	1	2
4. Do you exercise excessively?	0	1	2
5. Do you consume hydrogenated fats?	0	1	2
6. Do you drink fluoridated water?	0	1	2
7. Do you avoid cruciferous vegetables (e.g., cauliflower, brussel sprouts, asparagus)?	0	1	2
8. Do you have stress in your life?	0	1	2
9. Do you avoid red fruits or vegetables (e.g., tomatoes, cranberries, cherries)?	0	1	2
10. Do you smoke or are you exposed to secondhand smoke or smog?	0	1	2

Symptoms

11. Do you have age spots?	0	1	2
12. Do you have hemorrhoids?	0	1	2
13. Do you get bloody noses?	0	1	2
14. Do you bruise easily or have varicose veins?	0	1	2
15. Do you have deteriorating eye sight?	0	1	2
16. Do you experience hyperactivity or excessive nervousness?	0	1	2
17. Do you have bleeding gums?	0	1	2
18. Do you have excessive wrinkling of the skin/premature aging?	0	1	2
19. Do you have stiff joints?	0	1	2

Total: _____

Section 4:

Lifestyle Choices

1. Do you eat less than four servings of grain each day?	0	1	2
2. Do you eat less than three servings of fresh fruit each day?	0	1	2
3. Do you eat less than two servings of fresh, dark-colored vegetables each day?	0	1	2
4. Do you eat less than two servings of dairy products each day?	0	1	2
5. Do you eat food that is not organically grown?	0	1	2

Symptoms

6. Do you have persistent leg cramps?	0	1	2
7. Do you have poor stamina?	0	1	2
8. Do you have excessive hair loss?	0	1	2
9. Do you have graying of the hair?	0	1	2
10. Do you have trouble sleeping?	0	1	2
11. Do your muscles feel weak after performing usual daily activities?	0	1	2
12. Do you have a craving for alcohol?	0	1	2
13. Do you have a small appetite?	0	1	2
14. Do you feel nervous or are you unable to concentrate?	0	1	2

Total: _____

Section 5:

Lifestyle Choices

1. Do you avoid exercise?	0	1	2
2. Do you eat fatty foods?	0	1	2
3. Do you eat white bread?	0	1	2
4. Do you eat candy or sweets?	0	1	2
5. Do you drink sweet beverages?	0	1	2
6. Do you have stress in your life?	0	1	2

Symptoms

7. Do you have cravings for sweets or sugars?	0	1	2
8. Do you experience weakness or faintness between meals?	0	1	2
9. Are you unable to gain weight or lose unwanted fat?	0	1	2
10. Do you experience excessive fatigue during workouts?	0	1	2
11. Do you feel you have unstable blood sugar levels?	0	1	2
12. Do you have feelings of dizziness or ringing in the ears?	0	1	2
13. Do you crave fatty foods?	0	1	2
14. Do you have an excessive appetite?	0	1	2
15. Does it seem difficult to strengthen your muscles?	0	1	2
16. Do you have pains in the upper right quadrant of the stomach?	0	1	2
17. Is your triglyceride level above 115?	0	1	2
18. Do you experience mood swings?	0	1	2
19. Do you experience nervousness or shakiness?	0	1	2

Total: _____

Section 6:

Lifestyle Choices

1. Are you taking or have you taken antibiotics within the last 90 days?	0	1	2
2. Do you eat commercially raised meat?	0	1	2
3. Do you consume commercially produced dairy products?	0	1	2
4. Do you drink non-filtered water?	0	1	2
5. Do you drink chlorinated water?	0	1	2
6. Do you drink carbonated beverages?	0	1	2
7. Do you drink coffee or tea?	0	1	2
8. Do you drink alcoholic beverages?	0	1	2
9. Have you undergone surgery within the last 90 days?	0	1	2
10. Have you done any foreign travel within the last 90 days?	0	1	2

Symptoms

11. Do you have persistent diarrhea?	0	1	2
12 Do you get sick often?	0	1	2
13. Do you get frequent cold sores?	0	1	2
14. Do you have a history of food poisoning?	0	1	2
15. Do you have persistent flatulence or gas?	0	1	2
16. Do you have bad breath?	0	1	2

Total: _____

Section 7:

1. Do you feel that you have PMS?	0	1	2
2. Are you moody?	0	1	2
3. Do you have monthly cramps?	0	1	2
4. Do you have a low sex drive?	0	1	2
5. Do you have poor sex organ development?	0	1	2
6. Do you have anemia?	0	1	2
7. Do you experience a persistent level of low energy?	0	1	2

Section 7: continued

	No	Yes	Often
8. Do you have pale skin?	0	1	2
9. Do you have depression?	0	1	2
10. Are you uncomfortable no matter what?	0	1	2
11. Do you have cracking around lips or a white tongue?	0	1	2

Total: _____

Section 8:

1. Are you under 18 years old, pregnant, or an endurance athlete?	0	1	2
2. Do you have anemia?	0	1	2
3. Do you have low energy, fatigue?	0	1	2
4. Do you eat a low fiber diet?	0	1	2
5. Do you eat a low carbohydrate diet?	0	1	2
6. Do you have clammy skin?	0	1	2
7. Do you have persistent shortness of breath?	0	1	2
8. Do you have frequent headaches?	0	1	2
9. Do you have ridges in you fingernails?	0	1	2
10. Do you experience excessive menstrual flow?	0	1	2

Total: _____

Section 9:

1. Do you have high cholesterol (above 200)?	0	1	2
2. Do you have pain in the upper right quadrant of your stomach?	0	1	2
3. Do you experience distress from eating fatty foods?	0	1	2
4. Do you have dry skin?	0	1	2
5. Do you experience an unpleasant taste in your mouth?	0	1	2
6. Do you have a persistent burning in your stomach?	0	1	2
7. Do you have flatulence or gas after meals?	0	1	2
8. Do you eat a high fat diet?	0	1	2
9. Do you have a diet high in hydrogenated fats?	0	1	2
10. Do you eat red meats?	0	1	2

Total: _____

Section 10:

1. Have you had a recent traumatic injury within the last 90 days?	0	1	2
2. Do you have muscle pain?	0	1	2
3. Do you have muscle cramps?	0	1	2
4. Do you have cold hands and cold feet, or experience poor circulation?	0	1	2
5. Do you have pain in the joints in your legs, arms, hands or feet?	0	1	2
6. Are your injuries slow to heal?	0	1	2
7. Do you have disc problems?	0	1	2
8. Are you experiencing difficulty in strengthening muscles?	0	1	2
9. Do you have frequent fevers or infections?	0	1	2
10. Do you eat a lot of protein (more than 6 oz. per day)?	0	1	2

Total: _____

Section 11:

1. Do you work around toxic or nauseous chemicals?	0	1	2
2. Do you smoke or are you exposed to second hand smoke or smog?	0	1	2
3. Have you taken prescription drugs in the last 90 days?	0	1	2
4. Do you regularly experience constipation?	0	1	2
5. Do you have symptoms of bowel irritation?	0	1	2
6. Are you a heavy red meat eater?	0	1	2
7. Do you have stomach aches in the navel area?	0	1	2

Section 11: continued

8. Do you have difficulty in thinking clearly?	0	1	2
9. Do you have discoloration of the gums?	0	1	2
10. Do you have difficulty in responding to conventional treatments?	0	1	2

Total: _____

Section 12:

1. Do you have persistent illnesses?	0	1	2
2. Do you get yeast infections?	0	1	2
3. Are antibiotics ineffective for you?	0	1	2
4. Do you seem to get sick easily?	0	1	2
5. Do you have candida?	0	1	2
6. Do you have fungus problems?	0	1	2
7. Do you have athletes foot?	0	1	2
8. Do you have anal itching?	0	1	2
9. Do you have food allergies?	0	1	2
10. Do you have joint pain any where in your body?	0	1	2

Total: _____

SYMPTOM SURVEY FORM

Patient_____ Date_____ Doctor's Name_____

INSTRUCTIONS: CIRCLE (1) for MILD symptoms (occurring once or twice a year).
CIRCLE (2) for MODERATE symptoms (occurring several times a year).
CIRCLE (3) for SEVERE symptoms (you are aware of it almost constantly)
LEAVE THE QUESTION BLANK if the question does not apply to you.

GROUP ONE

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth-eyes-nose
5. 1 2 3 Pulse speeds after meals
6. 1 2 3 Keyed up – fail to calm down
7. 1 2 3 Cuts heal slowly
8. 1 2 3 Gag easily
9. 1 2 3 Unable to relax; startles easily
10. 1 2 3 Extremities cold, clammy
11. 1 2 3 Strong light irritates
12. 1 2 3 Urine amount reduced
13. 1 2 3 Heart pounds after retiring
14. 1 2 3 "Nervous" stomach
15. 1 2 3 Appetite reduced
16. 1 2 3 Cold sweats often
17. 1 2 3 Fever easily raised
18. 1 2 3 Neuralgia-like pains
19. 1 2 3 Staring, blinks little
20. 1 2 3 Sour stomach frequent

GROUP TWO

21. 1 2 3 Joint stiffness after arising
22. 1 2 3 Muscle-leg-toe cramps at night
23. 1 2 3 "Butterfly" stomach, cramps
24. 1 2 3 Eyes or nose watery
25. 1 2 3 Eyes blink often
26. 1 2 3 Eyelids swollen, puffy
27. 1 2 3 Indigestion soon after meals
28. 1 2 3 Always seems hungry; feels "lightheaded" often
29. 1 2 3 Digestion rapid
30. 1 2 3 Vomiting frequent
31. 1 2 3 Hoarseness frequent
32. 1 2 3 Breathing irregular
33. 1 2 3 Pulse slow; feels irregular
34. 1 2 3 Gagging reflex slow
35. 1 2 3 Difficulty swallowing
36. 1 2 3 Constipation, diarrhea alternating
37. 1 2 3 "Slow starter"
38. 1 2 3 Get "chilled" infrequently
39. 1 2 3 Perspire easily
40. 1 2 3 Circulation poor, sensitive to cold
41. 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42. 1 2 3 Eat when nervous
43. 1 2 3 Excessive appetite
44. 1 2 3 Hungry between meals
45. 1 2 3 Irritable before meals
46. 1 2 3 Get "shaky" if hungry
47. 1 2 3 Fatigue, eating relieves
48. 1 2 3 "Lightheaded" if meals delayed
49. 1 2 3 Heart palpitates if meals missed or delayed
50. 1 2 3 Afternoon headaches
51. 1 2 3 Overeating sweets upsets
52. 1 2 3 Awaken after few hours sleep – hard to get back to sleep
53. 1 2 3 Crave candy or coffee in afternoon
54. 1 2 3 Moods of depression – "blues" or melancholy
55. 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56. 1 2 3 Hands and feet go to sleep easily, numbness
57. 1 2 3 Sigh frequently, "air
58. 1 2 3 Aware of "breathing heavily"
59. 1 2 3 High altitude discomfort
60. 1 2 3 Opens windows in closed room
61. 1 2 3 Susceptible to colds and fevers
62. 1 2 3 Afternoon yawner
63. 1 2 3 Get "drowsy" often
64. 1 2 3 Swollen ankles worse at night
65. 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66. 1 2 3 Shortness of breath on exertion
67. 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68. 1 2 3 Bruise easily, "black and blue" spots
69. 1 2 3 Tendency towards anemia
70. 1 2 3 "Nose bleeds" frequent
71. 1 2 3 Noises in head, or "ringing in the ears"
72. 1 2 3 Tension under breastbone or feeling of "tightness", worse on exertion

GROUP FIVE

73. 1 2 3 Dizziness
74. 1 2 3 Dry skin
75. 1 2 3 Burning feet
76. 1 2 3 Blurred vision
77. 1 2 3 Itching skin and feet
78. 1 2 3 Excessive falling hair
79. 1 2 3 Frequent skin rashes
80. 1 2 3 Bitter, metallic taste in mouth in mornings
81. 1 2 3 Bowel movements painful or difficult
82. 1 2 3 Worrier, feels insecure
83. 1 2 3 Feeling queasy; headache over eyes
84. 1 2 3 Greasy foods upset
85. 1 2 3 Stools light-colored
86. 1 2 3 Skin peels on soles of feet
87. 1 2 3 Pain between shoulder blades
88. 1 2 3 Use laxatives
89. 1 2 3 Stools alternate from soft to watery
90. 1 2 3 History of gallbladder attacks or gallstones
91. 1 2 3 Sneezing attacks
92. 1 2 3 Dreaming, nightmare type bad dreams
93. 1 2 3 Bad breath (halitosis)
94. 1 2 3 Milk products cause distress
95. 1 2 3 Sensitive to hot weather
96. 1 2 3 Burning or itching anus
97. 1 2 3 Crave sweets

GROUP SIX

98. 1 2 3 Loss of taste for meat
99. 1 2 3 Lower bowel gas several hours after eating
100. 1 2 3 Burning stomach sensations, eating relieves
101. 1 2 3 Coated tongue
102. 1 2 3 Pass large amounts of foul-smelling gas
103. 1 2 3 Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hrs.
104. 1 2 3 Mucous colitis or
105. 1 2 3 Gas shortly after eating
106. 1 2 3 Stomach "bloating" after eating

GROUP SEVEN

(A)

107. 1 2 3 Insomnia
108. 1 2 3 Nervousness
109. 1 2 3 Can't gain weight
110. 1 2 3 Intolerance to heat
111. 1 2 3 Highly emotional
112. 1 2 3 Flush easily
113. 1 2 3 Night sweats
114. 1 2 3 Thin, moist skin
115. 1 2 3 Inward trembling
116. 1 2 3 Heart palpitates
117. 1 2 3 Increased appetite without weight gain
118. 1 2 3 Pulse fast at res
119. 1 2 3 Eyelids and face twitch
120. 1 2 3 Irritable and restless
121. 1 2 3 Can't work under pressure

(B)

122. 1 2 3 Increase in weight
123. 1 2 3 Decrease in appetite
124. 1 2 3 Fatigue easily
125. 1 2 3 Ringing in ears
126. 1 2 3 Sleepy during day
127. 1 2 3 Sensitive to cold
128. 1 2 3 Dry or scaly skin
129. 1 2 3 Constipation
130. 1 2 3 Mental sluggishness
131. 1 2 3 Hair coarse, falls out
132. 1 2 3 Headaches upon arising, wear off during day
133. 1 2 3 Slow pulse, below 65
134. 1 2 3 Frequency of urination
135. 1 2 3 Impaired hearing
136. 1 2 3 Reduced initiative

(C)

137. 1 2 3 Failing memory
138. 1 2 3 Low blood pressure
139. 1 2 3 Increased sex drive
140. 1 2 3 Headaches, "splitting or rending" type
141. 1 2 3 Decreased sugar tolerance

(D)

142. 1 2 3 Abnormal thirst
143. 1 2 3 Bloating of abdomen
144. 1 2 3 Weight gain around hips or waist
145. 1 2 3 Sex drive reduced or lacking
146. 1 2 3 Tendency toward ulcers, colitis
147. 1 2 3 Increased sugar tolerance
148. 1 2 3 Women: menstrual disorders
149. 1 2 3 Young girls: lack of menstrual function

(E)

150. 1 2 3 Dizziness
151. 1 2 3 Headaches
152. 1 2 3 Hot flashes
153. 1 2 3 Increased blood pressure
154. 1 2 3 Hair growth on face or body (female)
155. 1 2 3 Sugar in urine (not diabetes)
156. 1 2 3 Masculine tendencies (female)

(F)

157. 1 2 3 Weakness, dizziness
158. 1 2 3 Chronic fatigue
159. 1 2 3 Low blood pressure
160. 1 2 3 Nails, weak, ridged
161. 1 2 3 Tendency toward hive
162. 1 2 3 Arthritic tendencies
163. 1 2 3 Perspiration increase
164. 1 2 3 Bowel disorders
165. 1 2 3 Poor circulation
166. 1 2 3 Swollen ankles
167. 1 2 3 Crave salt
168. 1 2 3 Brown spots or bronzing of skin
169. 1 2 3 Allergies – tendency to asthma
170. 1 2 3 Weakness after colds, influenza
171. 1 2 3 Exhaustion – muscular and nervous
172. 1 2 3 Respiratory disorders

FEMALE ONLY

173. 1 2 3 Very easily fatigued
174. 1 2 3 Premenstrual tension
175. 1 2 3 Painful menses
176. 1 2 3 Depressed feelings before menstruation
177. 1 2 3 Menstruation excessive and prolonged
178. 1 2 3 Painful breasts
179. 1 2 3 Menstruate too frequently
180. 1 2 3 Vaginal discharge
181. 1 2 3 Hysterectomy/ovaries removed
182. 1 2 3 Menopausal hot flashes
183. 1 2 3 Menses scanty or missed
184. 1 2 3 Acne, worse at menses
185. 1 2 3 Depression of long standing

MALE ONLY

186. 1 2 3 Prostate trouble
187. 1 2 3 Urination difficult or dribbling
188. 1 2 3 Night urination frequent
189. 1 2 3 Depression
190. 1 2 3 Pain on inside of legs or heels
191. 1 2 3 Feeling of incomplete bowel evacuation
192. 1 2 3 Lack of energy
193. 1 2 3 Migrating aches and pains
194. 1 2 3 Tire too easily
195. 1 2 3 Avoids activity
196. 1 2 3 Leg nervousness at night
197. 1 2 3 Diminished sex drive

IMPORTANT

Please list below the five main physical complaints you have in order of their importance:

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