450 MAMARONECK AVE, HARRISON NY 10528 | DRKEALY.COM | (914) 703-4811

# Nutrition Questionnaire

| Name: | | Date: |
|---|---|---|
| Address: | | |
| City: | State: | Zip: |

| E-Mail Address: | | |
|---|---|---|
| Phone (H): | Phone (C): | Phone (W): |

| Date of Birth: |
|---|
| Height: |
| Weight: |
| Usual Body Weight: |

How did you hear about us? _____

If referred by someone, who? _____

**Please answer the following questions honestly so we can do our best to help you reach your goals.**

How many pounds would you like to lose? _____

What diets have you tried on your own? _____

Have you been advised by your physician to lose weight? _____

Do you eat because of emotions? _____

If yes, please explain: _____

_____

_____

How many time do you eat per day? _____

Describe **a full typical day's meals, snacks, and drinks,** and time of each (please be specific and very complete):

**Typical Day:**

_____

_____

_____

_____

_____

**Please write Yes or No.**

| | | |
|---|---|---|
| Do you smoke?_____ | How often?_____ | |
| Do you drink alcohol?_____ | How much/when?_____ | |
| Do you drink caffeine?_____ | What kind?_____ | How much/when?_____ |

Do you have any food allergies, restrictions, or sensitivities?

_____

_____

How is your dental health?_____

Do you have problems chewing or swallowing?_____

How often do you have a bowel movement?_____

Do you have Constipation or Diarrhea? _____

Do you have Nausea or Vomiting?_____

Do you exercise?_____If yes, what kind?_____

How often?_____Since when?_____

**Please circle any of the following that pertain to you (past or present):**

| | | | |
|---|---|---|---|
| Acne | Addiction (alcohol, drug) | Anemia | Anorexia |
| Anxiety | Arthritis (Rheumatoid or Osteo) | Bladder Infections | Bloating (gas or indigestions) |
| Chrohn's Disease | Thyroid Conditions | Cancer | Memory Loss or Confusion |
| Colitis | Chronic Fatigue | Respiratory Problems | Pregnant/Nursing |
| Depression | Diabetes 1 | Diabetes 2 | Panic Attacks |
| Difficulty losing weight | Skin Conditions | Emotional problems | Emphysema |
| Fainting | Gall Bladder Problems | Gout | Hair Loss |
| Headaches | Heart Disease | Liver Problems | Hemorrhoids |
| Stroke | High Blood Pressure | High Cholesterol | HIV |
| Hot Flashes | Hypoglycemia | Insomnia | Ulcer |
| Kidney Stones | | | |

Please rate the following: (Circle the appropriate answer)

**Daily Stress level:** Excellent Good Fair Poor

How many hours of sleep do you get on average each night?_____

Do you have any sleeping problems?

_____

_____

Do you take any nutritional supplements or vitamins?_____If yes, which ones? (Be specific, attach separate sheet if necessary).

_____

_____

_____

_____

_____

Please least any prescriptions or over the counter medications you take on a regular basis:

_____

_____

_____

_____

_____

**Medical History:** Please least any disease, illness, or ailments

_____

_____

_____

_____

_____