# Nutri-Wellness

## NSP SYMPTOMOLOGY QUESTIONNAIRE

# LIFESTYLE ASSESSMENT

Name: _____

Date: _____ Age: _____ Sex: _____

***Please answer each of the following questions. Please use the back of the page for additional space.***

What is your purpose in coming here today?

_____

What are your main health concerns/complaints?

_____

_____

Have you ever been diagnosed with an ailment related to your main health concern(s)? _____

Any trauma or loss in the last 5 years? _____

What level of stress do you feel you are experiencing at this time?

Minimal ☐ Average ☐ Considerable ☐ Unbearable ☐

What are the major causes or factors of your stress? (check all that apply)

☐ financial ☐ career ☐ personal ☐ marriage ☐ health

☐ family ☐ spiritual ☐ unfulfilled expectations

☐ other (please elaborate) _____

How does your stress manifest itself? _____

_____

Do you use any coping mechanisms? _____

What do you do for exercise? (indicate type, frequency and time) _____

_____

How many hours on average do you sleep daily? (include naps) _____

What time do you go to sleep? _____ Awaken? _____

Do you awaken feeling rested? Yes ☐ No ☐

What is your occupation? _____

Do you enjoy your work? Yes ☐ No ☐ Sometimes ☐

How many hours each day do you work? _____

At what times do you start and end work? _____

Do you smoke? Yes ☐ No ☐ If yes, how much and for how long?

_____

If no, does anyone in your household or workplace smoke? Yes ☐ No ☐

Do you wish to gain weight? ☐ lose weight? ☐ how much? _____

How many hours do you spend daily, on average:

Driving _____ watching television _____ reading _____ in front of computer _____

What are your interests and hobbies? _____

_____

Do you vacation regularly? Yes ☐ No ☐

When was your last vacation? _____

Do you actively participate in any spiritual discipline (church, religious group, meditation, etc.) Yes ☐ No ☐

*For Office use only:*

# LIFESTYLE ASSESSMENT

*For Office use only:*

**MEDICAL HISTORY:**

Are you currently taking any medication? Yes ☐ No ☐
List Reason(s) _____

Please list any vitamins, minerals, herbal or homeopathic remedies you are currently taking and the amounts/dosages: _____

_____

_____

Do you have any allergies or sensitivities? If so, please list:

_____

Do you have any silver-mercury fillings? Yes ☐ No ☐

Have you ever been:
Diagnosed with an illness? Explain _____

_____

Hospitalized? Reason _____

How often do you have a bowel movement? _____
Do you strain to have a bowel movement? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____
Do you have loose bowel movements? Yes ☐ No ☐ Occasionally ☐
Related to particular food or circumstances? _____

Do you use recreational drugs? Yes ☐ No ☐
If yes, how often and what type? _____
Have you ever been treated for drug and/or alcohol dependency? Yes ☐ No ☐
If yes, please circle which one.

**FAMILY HISTORY:**

Hereditary Diseases: Use "F" for father, "M" for mother, "S" for sibling, "G" for grandparent, "O" for others

| | | |
|---|---|---|
| _____ Heart Disease | _____ Diabetes | _____ Allergies |
| _____ Hypertension | _____ Arthritis | _____ Mental Illness |
| _____ Intestinal Disease | _____ Osteoporosis | _____ Alcoholism |
| _____ Kidney Dysfunction | _____ Ulcers | _____ Asthma |
| _____ Gall Bladder Problems | _____ Cancer, type: _____ | |

Other (please list) _____

**FEMALES:**

Are you or could you be pregnant? Yes ☐ No ☐
Are you pre-menopausal or menopausal? Yes ☐ No ☐
Are you experiencing any menopausal symptoms? Yes ☐ No ☐
If yes, please specify _____
Have you had a bone density test? Yes ☐ No ☐
If yes, what was the result? _____

## LIFESTYLE ASSESSMENT

*For Office use only:*

**DIETARY HABITS:**

How many times a day do you eat:

Main Meals _____ Times of day: _____

Snacks _____ Times of day: _____

Do you eat meals: with family ☐ home alone ☐ on the run ☐

restaurant ☐ fast food ☐

Do you feel there are restrictions to your diet due to the preferences of others - Family, roommates, etc? Yes ☐ No ☐ If yes, explain _____

_____

How many ½ cup servings of each do you typically eat in a day:

_____ Fruit: Fresh ☐ Dried ☐ Canned ☐

_____ Vegetables: Cooked ☐ Raw ☐

_____ Whole Grains

_____ Protein: Type _____

_____ Dairy Products: Type _____

_____ Other: Specify _____

Give examples of your typical meals:

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

Snacks: _____

_____

**Do you eat or use (indicate "1" for rarely, "2" for regularly, "3" for often)**

☐ aluminum pans ____ ☐ margarine ____ ☐ candy ____

☐ microwave ____ ☐ fried foods ____ ☐ refined foods____

☐ luncheon meats ____ ☐ cigarettes ____ ☐ fast foods ____

☐ Nutra Sweet/Aspartame ____

Please indicate how many cups of the following you drink per day:

____ bottled or spring water ____ tap water ____ milk *(1% or 2%)*

____ fresh fruit juices ____ beer ____ milk *(skim)*

____ fruit juices *(prepared)* ____ red wine ____ tea

____ fresh vegetable juices ____ white wine ____ herbal tea

____ soft drinks *(regular)* ____ other alcoholic ____ coffee

____ soft drinks *(diet)* other (specify) _____

## LIFESTYLE ASSESSMENT

*For Office use only:*

Are you a: ☐ meat eater? ☐ vegetarian? ☐ vegan?

How often do you eat meat? ☐ daily ☐ 3-5/week ☐ once/week or less

How often do you consume dairy products?

☐ daily ☐ 3-5/week ☐ once/week or less

What are your favourite foods? _____

How often do you eat them? _____

Do you avoid certain foods? If so, why?

_____

_____

Do you experience any symptoms if meals are missed? Explain:

_____

Do you experience any symptoms after meals? Explain:

_____

Comments: _____

_____

_____

_____

_____

_____

**CLIENT STATEMENT:**

I understand and acknowledge that the services provided are at all times restricted to consultation on the subject of health matters intended for general well-being, and are not meant for the purposes of medical diagnosis, treatment or prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine. This statement is being signed voluntarily.

Date: _____

Signature: _____

Name: _____
(please print)

Address: _____

City: _____ Prov: _____ P.C.: _____

Phone: (H) _____ (B) _____

*All information contained on this form will be kept strictly confidential.*

# DAILY FOOD LOG

| DAY | BREAKFAST | LUNCH | DINNER | SNACK |
|---|---|---|---|---|
| **SUN** | | | | |
| **MON** | | | | |
| **TUE** | | | | |
| **WED** | | | | |
| **THU** | | | | |
| **FRI** | | | | |
| **SAT** | | | | |

## CLIENT ASSESSMENT

**COMPLETE LEFT SIDE OF FORM ONLY:** If any of the following symptoms or activities have occurred *within the past three months* (unless otherwise specified), please indicate by checking: **1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.

| | ***Please complete this section*** | | | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | General fatigue or weakness | | | | | | | | | | | | |
| 2 | Difficulty losing weight | | | | | | | | | | | | |
| 3 | Frequent illness/infections | | | | | | | | | | | | |
| 4 | High stress Lifestyle | | | | | | | | | | | | |
| 5 | Smoking | | | | | | | | | | | | |
| 6 | Drinking more than 2 cups of coffee/day | | | | | | | | | | | | |
| 7 | Bad breath and/or body odour | | | | | | | | | | | | |
| 8 | Constipation | | | | | | | | | | | | |
| 9 | Bags under eyes | | | | | | | | | | | | |
| 10 | Crave sugars, bread, alcohol | | | | | | | | | | | | |
| 11 | Difficulty digesting certain foods | | | | | | | | | | | | |
| 12 | Have used antibiotics in past 10 years | | | | | | | | | | | | |
| 13 | Allergies | | | | | | | | | | | | |
| 14 | Poor concentration or memory | | | | | | | | | | | | |
| 15 | Belching or burping after meals | | | | | | | | | | | | |
| 16 | Skin/complexion problems | | | | | | | | | | | | |
| 17 | Frequent consumption of red meat | | | | | | | | | | | | |
| 18 | Regular use of dairy products | | | | | | | | | | | | |
| 19 | Heavy alcohol consumption | | | | | | | | | | | | |
| 20 | Exposure to toxins/chemicals | | | | | | | | | | | | |
| 21 | Frequent mood swings | | | | | | | | | | | | |
| 22 | Depressed and/or irritable | | | | | | | | | | | | |
| 23 | Brittle fingernails | | | | | | | | | | | | |
| 24 | Dry, brittle hair, split ends | | | | | | | | | | | | |
| 25 | High fat/high cholesterol diet | | | | | | | | | | | | |
| 26 | Nervousness/anxiety/tension/worry | | | | | | | | | | | | |
| 27 | Insomnia/restless sleep | | | | | | | | | | | | |
| 28 | Low fibre diet | | | | | | | | | | | | |
| 29 | Muscle cramps | | | | | | | | | | | | |
| 30 | Sleepy when sitting up | | | | | | | | | | | | |
| 31 | Female: menstrual cramps | | | | | | | | | | | | |
| 32 | Bronchitis/asthma/pneumonia/emphysema | | | | | | | | | | | | |
| 33 | Cellulite | | | | | | | | | | | | |
| 34 | Cold hands and feet | | | | | | | | | | | | |
| 35 | Varicose veins | | | | | | | | | | | | |
| 36 | Feeling out of control | | | | | | | | | | | | |
| 37 | Food/chemical sensitivities | | | | | | | | | | | | |
| 38 | Frequent yeast/fungus problems | | | | | | | | | | | | |
| 39 | Bones break easily, osteoporosis | | | | | | | | | | | | |
| 40 | Too little exercise | | | | | | | | | | | | |
| | **SCORES SUBTOTAL** | | | | | | | | | | | | |

**Right Side for Office Use Only**

**(Check: 1** for mild or rarely occurring, **2** for moderate or regularly occurring, **3** for severe or often occurring, or **leave blank** if the symptom/statement does not apply.)

| *Please complete this section* | | | Right Side for Office Use Only | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **SUBTOTALS** | | | | | | | | | | | | |
| 41 | Excessive mucous | | | | | | | | | | | | |
| 42 | Short of breath climbing stairs | | | | | | | | | | | | |
| 43 | Tingling in lips, fingers, arms, legs | | | | | | | | | | | | |
| 44 | Chest pains | | | | | | | | | | | | |
| 45 | Very rapid or slow heart beat | | | | | | | | | | | | |
| 46 | Painful, hard or thin bowel movements | | | | | | | | | | | | |
| 47 | Alternating constipation/diarrhea | | | | | | | | | | | | |
| 48 | Recurrent bladder infections | | | | | | | | | | | | |
| 49 | Female: Menopause, hot flashes | | | | | | | | | | | | |
| 50 | Female: PMS | | | | | | | | | | | | |
| 51 | Difficult urination | | | | | | | | | | | | |
| 52 | Swollen glands, puffy throat | | | | | | | | | | | | |
| 53 | Lower abdominal pain | | | | | | | | | | | | |
| 54 | Frequent need to urinate | | | | | | | | | | | | |
| 55 | Joint pain | | | | | | | | | | | | |
| 56 | Sinus inflammation/discharge | | | | | | | | | | | | |
| 57 | Arthritis | | | | | | | | | | | | |
| 58 | Sudden weight gain/loss | | | | | | | | | | | | |
| 59 | Headaches/Migraines | | | | | | | | | | | | |
| 60 | Female: Taking birth control pills | | | | | | | | | | | | |
| 61 | Lower back pains | | | | | | | | | | | | |
| 62 | Dry, flaky skin | | | | | | | | | | | | |
| 63 | Drink less than 6 glasses of fluids/day | | | | | | | | | | | | |
| 64 | Water retention | | | | | | | | | | | | |
| 65 | Low sex drive | | | | | | | | | | | | |
| 66 | Feeling heavy/bloated after meals | | | | | | | | | | | | |
| 67 | Chronic cough | | | | | | | | | | | | |
| **SCORES TOTAL** | | | | | | | | | | | | | |

**SYSTEMS RATING TABLE:** For Office Use Only

| | | |
|---|---|---|
| 1. | Digestive | |
| 2. | Intestinal | |
| 3. | Circulatory/Cardiovascular | |
| 4. | Nervous | |
| 5. | Immune/Lymphatic | |
| 6. | Respiratory | |
| 7. | Urinary | |
| 8. | Glandular/Endocrine | |
| 9. | Structural | |
| 10. | Reproductive | |

**COMMENTS:**

## DIGESTIVE SYSTEM

*NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM*:
*Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.*

### UNDERACTIVE STOMACH

| | |
|---|---|
| Excessive gas, belching or burping after meals | |
| Stomach bloated after eating | |
| Sleepy after eating | |
| Longitudinal striations on fingernails | |
| Eat when rushed/in a hurry | |
| Halitosis | |
| Full feeling after heavy meat meal | |
| Heavy, tired feeling after eating | |
| Nausea after taking supplements | |
| Acne | |
| Undigested food in the stool | |

### OVERACTIVE STOMACH

| | |
|---|---|
| Stomach pain 1 hour after eating or at night | |
| Burning sensation in stomach | |
| Pain aggravated by worry/tension | |
| Hiatal hernia | |
| Gastritis, gastric ulcer | |
| Nausea, vomiting | |
| Sensation of acidity in abdominal area | |
| Heartburn, indigestion | |
| Blood in stool | |
| Lower back pain | |
| Long term aspirin use | |

### LIVER

| | |
|---|---|
| Yellow or pale fingernails | |
| Skin oily on nose and forehead | |
| Fats/greasy foods cause nausea, headaches | |
| Vertical white streaks on fingernails | |
| Onions, cabbage, radishes, cucumbers cause bloating /gas | |
| Bad breath; bad taste in mouth | |
| Excess body odour | |
| High cholesterol/high cholesterol diet | |
| Stiff, aching muscles | |
| Migraine headaches | |
| Discomfort underneath right ribcage | |
| Food allergies | |
| Irritable, easily angered | |
| Weight gain around the abdomen | |
| Yellow palms | |
| Jaundice | |
| Poor concentration | |
| Difficulty losing weight | |
| Acne, boils, rashes, psoriasis or eczema | |
| Constipation | |

### PANCREAS

| | |
|---|---|
| Severe abdominal pain | |
| Nausea and vomiting | |
| Slow digestion; feel full for hours after eating | |
| Fever | |
| Alcohol addiction | |
| Jaundice | |

### GALL BLADDER

| | |
|---|---|
| Gall stones; history of gall stones | |
| Stool appears clay-coloured, foul odoured | |
| Constipation | |
| High cholesterol diet; High blood cholesterol levels | |
| Severe pain in right upper abdomen | |

### HYPOGLYCEMIA

| | |
|---|---|
| Hungry up to 3 hours after eating | |
| Strong, sudden cravings for sweets, starches coffee or alcohol | |
| Nervous/anxious feelings relieved by eating | |
| Irritable if late for or skip a meal | |
| Overweight | |
| Addicted to coffee with sugar and/or colas | |
| Frequent “midnight snacks” | |
| Family history of diabetes | |
| Fatigue | |
| Frequent headaches | |
| Fainting spells | |
| Depression | |
| Lose temper easily | |

## INTESTINAL SYSTEM

*NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM:*
*Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.*

### CANDIDIASIS

| | |
|---|---|
| Extreme fatigue | |
| Recurrent vaginal infections | |
| Frequent use of antibiotics | |
| White coated tongue, oral thrush | |
| Crave sugars, bread, alcohol | |
| Headaches | |
| Tonsillitis, recurrent strep throat | |
| Itchy, watery or dry eyes | |
| Skin flushes | |
| Chronic indigestion, frequently use antacids | |
| Always cold, especially in extremities | |
| F: PMS | |
| Pain in pelvic area | |
| Abdominal gas and bloating | |
| Loss of sex drive | |
| Cystitis, repeated bladder infection | |
| Increasing food and chemical sensitivities; severe reaction to tobacco, perfume, etc. | |
| F: endometriosis/ovary problems | |
| Chronic diarrhea | |
| Hives, psoriasis, acne, skin rashes | |
| Rectal itching | |
| Abnormal muscle aches from exercise | |
| Excessive wax in ears | |
| Unexpected/unexplained weight gain | |
| Impotence | |
| Canker sores | |
| Athlete's foot, finger/toenail fungus, ringworm | |
| Jock itch | |
| "Brain fog" | |
| Irritability | |
| Memory loss | |
| Mental confusion | |
| Depression or anger for no reason | |
| Anxiety/panic attacks | |
| Inability to concentrate | |
| Phobic/compulsive | |
| Lethargy | |
| Mood swings | |
| Itchy ears, nose, anus | |

### PARASITES

| | |
|---|---|
| Forgetfulness | |
| Slow reflexes | |
| Gas and bloating | |
| Unclear thinking | |
| Loss of appetite | |
| Yellowish or pale face | |
| Fast heartbeat | |
| Heart pain | |
| Pain in navel | |
| Eating more than normal but still feeling hungry | |
| Blurry or unclear vision | |
| Pain in the back, thighs, shoulders | |
| Numb hands | |
| Drooling while sleeping | |
| Damp lips at night | |
| Dry lips during the day | |
| Grind teeth while asleep | |
| Bedwetting | |
| Lethargy; chronic fatigue | |
| Dark circles under eyes | |
| Cancer | |

## LYMPHATIC / IMMUNE SYSTEM

*NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM:*
*Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.*

### THYMUS (IMMUNITY)

| | |
|---|---|
| Excessive sleep | |
| Very susceptible to infections | |
| Swollen glands: tonsils, throat, armpits | |
| History of cancer, MS, Parkinson's arthritis | |
| Loss of appetite | |
| Headaches | |
| Soreness on both sides of neck at shoulder | |
| Feel puffiness in throat | |
| Look older than chronological age | |
| Flu-like symptoms often occur | |
| Lupus | |

### ALLERGIES

| | |
|---|---|
| Acne, psoriasis, dermatitis, eczema | |
| Rapid pulse, heart irregularities | |
| Frequent headaches | |
| Hay fever | |
| Frequent cravings for certain foods | |
| Periods of blurred vision | |
| Repeated ear trouble | |
| Hyperactivity | |
| Dizzy spells | |
| Periods of confusion | |
| Poor concentration | |
| Epilepsy | |
| Muscle cramps or spasms | |
| Abnormal body odour | |
| Excessive sweating, night sweats | |
| Bowel disease: IBS, IBD, Crohn's, etc. | |
| Joint pains or stiffness | |
| Frequent night urination | |
| Wheezing | |
| Pale face | |
| Hives | |
| Nose runs constantly | |
| Noticeable changes in writing throughout day | |
| Nosebleeds | |
| Bloating or gas after eating certain foods | |
| Canker sores | |
| Dark circles under eyes | |
| Stuffy nose | |

## GLANDULAR / ENDOCRINE SYSTEM

*NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM:*
*Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.*

### UNDERACTIVE THYROID / HYPOTHYROID

| | |
|---|---|
| Distinct, lethargic tiredness or sluggishness | |
| Cold hands or feet | |
| Mercury amalgams (fillings) | |
| Gain weight easily, fail to lose on diets | |
| Constipation, less than one bowel movement a day | |
| Low energy in the morning | |
| Low pulse rate | |
| Low body temperature, especially at bed rest | |
| Hair dry, brittle, dull, lifeless | |
| Flaky, dry rough skin | |
| Feel stiff after sitting still for some time | |
| Mood swings | |
| Unusually square and wide fingernails | |
| High cholesterol | |
| Diminished sex drive | |

### PITUITARY

| | |
|---|---|
| Infertility or impotence | |
| Headaches affecting one side of head | |
| F: loss of menstrual function | |
| Moody | |
| Overweight from waist down | |
| Overweight from waist up | |
| Excessive urination | |
| Pain in little finger of left hand | |
| Swelling in ankles, fingers, feet | |
| Cold hands or feet | |
| Pain in left side of upper neck | |

### OVERACTIVE THYROID / HYPERTHYROID

| | |
|---|---|
| Losing weight without trying | |
| Heart races while at rest | |
| Feel warm/flushed at room temperature | |
| Hands shake or tremble | |
| Protruding tongue | |
| Heart palpitations | |
| Nervous behaviour, hyperactivity | |
| Insomnia | |
| Increased appetite | |
| Frequent bowel movements, diarrhea | |
| Excessive sweating without exercising | |

### ADRENALS

| | |
|---|---|
| Stress or emotional upsets cause exhaustion | |
| Blood pressure decreases when going from a lying position to a standing position | |
| Perspire excessively | |
| Neck and/or shoulder tension | |
| Frequent headaches | |
| Bow lines (depressed furrows) on fingernails | |
| Occasional cold sweats | |
| Tightness or lump in throat, especially when emotionally disturbed | |
| High or low blood pressure | |
| Rapid pulse | |
| Short temper | |
| Puffy face | |

## STRUCTURAL-MUSCULAR / SKELETAL SYSTEM

*NOW PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRES USING THE SAME RATING SYSTEM:*
*Leave blank if symptom or activity does not apply, 1 for mild or rarely occurring, 2 for moderate or regularly occurring, 3 for severe or often occurring.*

### SKELETAL

| | |
|---|---|
| Pain, swelling, stiffness in joints | |
| Joint inflammation (rheumatoid arthritis) | |
| Pain, stiffness, inflammation of spine | |
| Facial pain | |
| Joints make popping sounds | |
| Gout | |
| Joints make sounds like crinkling cellophane | |
| Ankylosing spondylitis | |
| Bones fracture easily | |
| Gradual loss of height | |
| Tooth loss; teeth “falling out” | |
| Lack of exercise | |
| Rounding of shoulders; stooping | |
| F: Menopause | |
| Pain in forearm or biceps | |
| Cramps in calf muscle during sleep or exercise | |
| Painful cramping of feet or toes | |
| Teeth prone to decay, frequent toothaches | |
| Malformation of bones | |
| Insomnia | |
| Muscles weak, weak grip, light objects feel heavy | |
| Heart palpitations | |
| Diet high in animal foods (meat, dairy, eggs) | |

### MUSCULAR

| | |
|---|---|
| Muscle pain | |
| Muscle weakness | |
| Sprains; muscle strains | |
| Muscle(s) spasm | |

### NEUROMUSCULAR

| | |
|---|---|
| Muscles wasting in some part of the body | |
| Numbness or loss of sensation | |
| Mood swings and/or depression | |
| Blurred or double vision | |
| Tingling and/or numbness, especially in extremities | |
| Loss of balance and / or coordination | |
| Muscular stiffness | |
| Difficulty breathing | |
| M: impotence | |
| Tremors | |
| Loss of peripheral vision | |
| Slurred speech | |
| Objects fall from hands, reach in wrong place | |
| Hands tremble | |
| Impaired speech | |