

Dr. Ron Grabowski, R.D., D.C.

Nutritional Questionnaire

The following questionnaire has been developed to help evaluate your nutritional needs and/or status. This process is only as accurate as the information that you provide. If you feel that the conditions listed below do not fully explain your signs/symptoms, please elaborate during our personal consultation. I would like to remind you that all of this information is strictly confidential unless you state otherwise.

Last Name: _____ First Name: _____

Street Address: _____ Apt#: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Occupation: _____

Male Female Birth date: ____/____/____ Age: _____

Height: _____ Weight: _____ Goal Weight: _____

Purpose for Consultation: _____

Who referred you to this office?

Dr. Mr. Mrs. Ms. _____

Address: _____

City: _____ State: _____ Zip Code: _____

Please check the signs/symptoms or conditions that you presently have or have had in the past.

Cardiovascular (heart) Conditions

	Present	Past
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cholesterol (elevated)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Edema (swelling)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> EKG Abnormality	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hypotension (low blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Intermittent claudication	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tachycardia (rapid heart beat)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Triglycerides (elevated)	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Notes:

Dermatologic Conditions

	Present	Past
<input type="checkbox"/> Acne (Rosacea)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acne (Pustular)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acrodermatitis enteropathica	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Alopecia (hair loss)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Canker sores (mouth ulcers)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cold sores (Herpes simplex I)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dermatitis (Seborrheic)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ecchymoses	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eczema	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Follicular Hyperkeratosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hair color (premature grey)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hyperhidrosis (excessive sweating)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Koilonychia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Leukonychia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin, dry	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin (eruptions)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Skin (pigmentation)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vitiligo	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Wound healing (poor)	<input type="checkbox"/>	<input type="checkbox"/>

Doctor's Notes:

Gastrointestinal Conditions

	Present	Past
<input type="checkbox"/> Abdominal cramps	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Achalasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Anorexia nervosa	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bulimia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Celiac disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Colitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Constipation	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crohn’s Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Duodenal ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dumping Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fat malabsorption	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gastric ulcer	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gastritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gastroesophageal Reflux (GERD)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hiatal hernia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Indigestion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Irritable bowel syndrome (IBS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Malabsorption	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nausea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Small Intestinal Bacteria Overgrowth	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vomiting	<input type="checkbox"/>	<input type="checkbox"/>

Doctor’s Notes:

Musculoskeletal Conditions

	Present	Past
<input type="checkbox"/> Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Carpal Tunnel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Facial twitching	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fatigue (generalized)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fractures (stress)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gout	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscular dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Myalgia (muscle pain)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteomalacia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Psoriatic arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Restless Legs Syndrome (RLS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Rickets	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tendinitis	<input type="checkbox"/>	<input type="checkbox"/>

Neurological Conditions

	Present	Past
<input type="checkbox"/> Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Ataxia (abnormal gait)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Autism	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Beri Beri	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Burning feet	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Confusion	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Convulsions	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dementia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Depression	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Diabetic neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Headaches (tension/migraine/cluster)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hyporeflexia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Memory loss (short-term / long-term)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Neuropathy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Paresthesia's	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Parkinson's disease	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Raynaud's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tinnitus (ringing in ears)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Tremors	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vertigo (dizziness)	<input type="checkbox"/>	<input type="checkbox"/>

Nutritional Considerations

	Present	Past
<input type="checkbox"/> Carbohydrate loading	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fasting (chronic)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Fiber intake (high)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Protein intake (high)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Polyunsaturated fat intake (high)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Salt intake (high)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Saturated fat intake (high)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vegetarian diet	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weight loss (involuntary)	<input type="checkbox"/>	<input type="checkbox"/>

Obstetrics/Gynecology Conditions

	Present	Past
<input type="checkbox"/> Amenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Breast feeding (Postnatal)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cervical dysplasia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Dysmenorrhea	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Eclampsia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Endometriosis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Gestational diabetes	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Infertility	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Menorrhagia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Placenta abruptio	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pre-eclampsia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Premenstrual Syndrome (PMS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pregnant	<input type="checkbox"/>	<input type="checkbox"/>

Ophthalmology Conditions

	Present	Past
<input type="checkbox"/> Bitot's spots	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cataracts	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Conjunctiva, dryness (Dry eyes)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Macular degeneration	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nyctalopia (nightblindness)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Pterygium	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Retinitis pigmentosa	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Vision loss	<input type="checkbox"/>	<input type="checkbox"/>

Renal/Urinary Conditions

	Present	Past
<input type="checkbox"/> Bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Benign prostatic hypertrophy	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hemodialysis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Nephrolithiasis (kidney stones)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prostatitis	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Prostate carcinoma	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Renal failure	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Uremia	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Yeast infections (chronic)	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries

<i>Surgery</i>	<i>Date</i>
Adenoids removed	
Angioplasty	
Appendectomy	
Cholecystectomy (gallbladder)	
Colostomy	
Coronary by-pass (Open heart)	
Foot	
Gastric banding	
Gastric bypass	
Hemorrhoidectomy	
Hysterectomy (partial or complete)	
Ileostomy	
Knee	
Nephrectomy	
Thyroidectomy (Thyroid)	
Tonsillectomy	
Vasectomy	
Additional: Please list below	

Allergies

Medications	Food	Air borne

Amino Acids

Name	Brand	Dosage	Duration
5 - HTP			
Alanine			
Arginine			
Asparagine			
Cysteine			
Glutamine			
Glycine			
Histidine			
Isoleucine			
Leucine			
Lysine			
Methionine			
Phenylalanine			
Serine			
Taurine			
Threonine			
Tryptophan			
Tyrosine			
Valine			

Enteral Formulations

Name	Brand	Dosage	Duration
Chondroitin sulfate			
Creatine			
Enfamil			
Ensure			
Ensure Plus			
Glucosamine sulfate			
MSM			
Polycose			
Protein powder			
Similac			
Sustacal			

Herbal Products

Name	Brand	Dosage	Duration
Chamomile			
Cranberry			
Echinacea			
Evening primrose oil			
Feverfew			
Flax seed oil/capsules			
Garlic			
Hawthorn berry			
MACA			
Milk thistle			

Family History

Family Member	Living	Deceased	Medical History
Mother			
Father			
Brother(s)			
Sister(s)			

Social History

Smoke: Yes **Packs per day:** _____ **Duration:** _____
 No

Alcohol: Yes **Frequency:** _____ **Amount:** _____
 No

Dietary History

Please list a typical daily diet schedule. The more detailed you can document your dietary habits; the more likely Dr. Grabowski will be able to evaluate your dietary concerns.

Breakfast:**Midmorning snack:****Lunch:****Mid-afternoon snack:****Dinner:****Evening snack:****Number of glasses of water consumed each day: _____**