

Nutrition Assessment Questionnaire

by Faye Elahi (972) 743-1425

Name (Adult/ Child's Name) _____ Gender _____
 Address _____ 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. Reproduction of this questionnaire is prohibited without the written consent of its author, **Faye Elahi, M.A., M.S. Nutritionist.**

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

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

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

Q. 84-90 are for children only

84. Do you have speech impairments?	<u> </u> <u> </u>
85. Does your child verbalize his/her needs or does he/she scream or tantrum to make a need known? (ignore if adult)	<u> </u> <u> </u>
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)	<u> </u> <u> </u>
87. Are you physically aggressive? (SIB, hurting others, hurting things)?	<u> </u> <u> </u>
88. If yes, is there a noticeable pattern to when you are most likely to show physical aggression?	<u> </u> <u> </u>
89. Do you follow instructions easily? If not, what is the problem in following instructions? _____	<u> </u> <u> </u>

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:
_____	_____	_____
_____	_____	_____
_____	_____	_____