

Nourishing Wellness
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Certified Body Ecologist
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NUTRITIONAL CONSULTATION QUESTIONNAIRE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (home): _____ Phone (work): _____

Cell phone _____ E-mail _____

Date of Birth: _____ Height: _____ Weight: _____ Blood Type: _____

Marital Status: _____ How many children do you have? _____

Occupation: _____ Do you like your current career? _____

How did you hear about our Nutritional Services?

Reason for consultation and/or goals: _____

Do you drink caffeine? _____ How much/when? _____

Do you drink soda? _____ How much/when? _____

Do you drink alcohol? _____ How much/when? _____

Do you smoke? _____ How much/when? _____

Do you use recreational drugs? _____ How much/when? _____

Do you overeat? _____ If so, which foods and how often? _____

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

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a while? _____

Do you crave any of the following?

- | | | |
|------------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Sugar | <input type="checkbox"/> Meat | <input type="checkbox"/> Fat |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Desserts | <input type="checkbox"/> Milk | <input type="checkbox"/> Salt |
| <input type="checkbox"/> Bread | <input type="checkbox"/> Fried Foods | <input type="checkbox"/> Other _____ |

Which oils do you use/consume?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Soybean Oil | |

Rank your skin without lotion:

- ☐ Very Dry ☐ Dry ☐ Normal ☐ Oily ☐ Combination

How much water do you drink daily? _____

How often do you have bowel movements? _____

How often do you urinate? _____

How much sleep do you get on average each night? _____

Do you have problems sleeping? _____

How many silver amalgam fillings do you have in your mouth? _____

Root Canals? _____ Crowns/bridges? _____

Other dental problems? _____

Do you exercise? _____ If so, what kind? _____

How often? _____ When did you start? _____

Please rate the following:

Daily energy level:

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Good | <input type="checkbox"/> Poor |

Energy level after exercise:

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Good | <input type="checkbox"/> Poor |

Daily stress level:

- ☐ Very High ☐ Moderate
☐ High ☐ Low

General enjoyment of life:

- ☐ Excellent ☐ Fair
☐ Good ☐ Poor

Do you take any nutritional supplements or vitamins? _____

If yes, which ones? How much? (Attach sheet if necessary). Please bring your supplement bottles with you to your appointment.

Please list all prescription and over the counter medications that you take regularly and for what purpose? (Please bring your medications with you to your appointment.) _____

MEDICAL INFORMATION:

Who is your primary care physician?

Name _____ Phone _____

Address _____

When was the last time you had a complete physical? _____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, etc.)

Have you had any traumatic accidents, surgeries, or operations? _____

Please feel free to expand on any concerns you think are important and relevant to your health. _____

(over please)

Please check off any of the following which pertained to you past and circle the ones that you have now:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Lung Problems |
| <input type="checkbox"/> Addiction (Alcohol, Drugs) | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Malabsorption |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Memory Loss/Confusion |
| <input type="checkbox"/> Anorexia / Bulimia | <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anxiety or Nervousness | <input type="checkbox"/> Gout | <input type="checkbox"/> Nails – Poor Growth |
| <input type="checkbox"/> Arthritis (Rheumatoid / Osteo) | <input type="checkbox"/> Hair Loss / Poor Hair Growth | <input type="checkbox"/> Nails – White Spots |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Panic Attacks |
| <input type="checkbox"/> Bladder Infections (Cystitis) | <input type="checkbox"/> Heart Disease / Problems | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Bloating / Gas / Indigestion | <input type="checkbox"/> Heart Burn/GERD | <input type="checkbox"/> Pregnant / Nursing |
| <input type="checkbox"/> Blood Sugar Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Colds or Flu (Frequent) | <input type="checkbox"/> Herpes Simplex or Type II | <input type="checkbox"/> Severe Mood Swings |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> HIV | <input type="checkbox"/> Suicidal Tendencies |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Thyroid Imbalance |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Diabetes I (Insulin Dependant) | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Diabetes II | <input type="checkbox"/> Intestinal Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Jaundice | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Difficulty Losing Weight | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Difficulty Gaining Weight | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Loose Stools | <input type="checkbox"/> _____ |
| (Instability, sensitivity) | | |

Women - check any that pertain:

- ☐ PMS
- ☐ Irregular Periods
- ☐ Painful Periods
- ☐ Loss of Periods
- ☐ Birth Control Pills
- ☐ Loss of Libido
- ☐ Menopause
- ☐ Painful Intercourse
- ☐ Hysterectomy

Men – check any that pertain:

- ☐ Frequent Urination
- ☐ Difficulty Urination
- ☐ Difficulty with Erection
- ☐ Loss of Libido
- ☐ Prostate Enlargement

