

## ADULT NUTRIGENOMIC QUESTIONNAIRE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will also assist us to formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____			
Address: _____		City: _____ State: _____ ZIP: _____	
Home Phone: (____) _____ - _____		Birth Date: ____ / ____ / ____ Age: _____ month day year	
Work Phone: (____) _____ - _____		Place of Birth: _____ City or town & country if not US	
Occupation: _____			
Referred by: _____		Height: ____' ____" Weight: _____ Sex: _____	
Today's Date _____			

1. Please check appropriate box(es):

- |   |                                    |  |                          |
|---|------------------------------------|--|--------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic  | <input type="checkbox"/> Mediterranean     | <input type="checkbox"/> |
| Asian                                     |                                    |  |                          |
| <input type="checkbox"/> Native American  | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> |
| Other                                     |                                    |  |                          |

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
<b>Example:</b> Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			

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d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)  
 Example: Wendy, age 7, sister

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4. Do you have any pets or farm animals? Yes \_\_\_ No \_\_\_  
 If yes, where do they live? 1. \_\_\_ indoors 2. \_\_\_ outdoors 3. \_\_\_ both indoors and outdoors

5. Have you lived or traveled outside of the United States? Yes \_\_\_ No \_\_\_  
 If so, when and where?

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6. Have you or your family recently experienced any major life changes? Yes \_\_\_ No \_\_\_  
 If yes, please comment:

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7. Have you experienced any major losses in life? Yes \_\_\_ No \_\_\_  
 If so, please comment:

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8. How important is religion (or spirituality) for you and your family's life?  
 a. \_\_\_ not at all important  
 b. \_\_\_ somewhat important  
 c. \_\_\_ extremely important

9. How much time have you lost from work or school in the past year?  
 a. \_\_\_ 0-2 days  
 b. \_\_\_ 3-14 days  
 c. \_\_\_ > 15 days

10. Previous jobs:

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11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

Please do your best to answer the following questions:

- a. Did you feel safe growing up?  
 Yes                       No
- b. Have you been involved in abusive relationships in your life?  
 Yes                       No
- c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?  
 Yes                       No
- d. Do you currently feel safe in your home?  
 Yes                       No
- e. Do you feel safe, respected and valued in your current relationship?  
 Yes                       No
- f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?  
 Yes                       No
- g. Would you feel safer discussing any of these issues privately?  
 Yes                       No

12. Past Medical and Surgical History:

	<b>ILLNESSES</b>	<b>WHEN</b>	<b>COMMENTS</b>
a.	Anemia		
b.	Arthritis		
c.	Asthma		
d.	Bronchitis		
e.	Cancer		
f.	Chronic Fatigue Syndrome		
g.	Crohn’s Disease or Ulcerative Colitis		
h.	Diabetes		
i.	Emphysema		
j.	Epilepsy, convulsions, or seizures		
k.	Gallstones		
l.	Gout		
	<b>ILLNESSES</b>	<b>WHEN</b>	<b>COMMENTS</b>
m.	Heart attack/Angina		

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n.	Heart failure		
o.	Hepatitis		
p.	High blood fats (cholesterol, triglycerides)		
q.	High blood pressure (hypertension)		
r.	Irritable bowel		
s.	Kidney stones		
t.	Mononucleosis		
u.	Pneumonia		
v.	Rheumatic fever		
w.	Sinusitis		
x.	Sleep apnea		
y.	Stroke		
z.	Thyroid disease		
aa.	Other (describe)		
	<b>INJURIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ab.	Back injury		
ac.	Broken (describe)		
ad.	Head injury		
ae.	Neck injury		
af.	Other (describe)		
	<b>DIAGNOSTIC STUDIES</b>	<b>WHEN</b>	<b>COMMENTS</b>
ag.	Barium Enema		
ah.	Bone Scan		
ai.	CAT Scan of Abdomen		
aj.	CAT Scan of Brain		
ak.	CAT Scan of Spine		
al.	Chest X-ray		
am.	Colonoscopy		
an.	EKG		
ao.	Liver scan		
ap.	Neck X-ray		
aq.	NMR/MRI		
ar.	Sigmoidoscopy		

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as. Upper GI Series		
at. Other (describe)		
<b>OPERATIONS</b>	<b>WHEN</b>	<b>COMMENTS</b>
au. Appendectomy		
av. Dental Surgery		
aw. Gall Bladder		
ax. Hernia		
ay. Hysterectomy		
az. Tonsillectomy		
ba. Other (describe)		
bb. Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

**< 5 times**                      **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

15. How often have you have taken oral steroids (e.g., Cortisone, Prednisone, etc.)?

**< 5 times**                      **> 5 times**

Infancy/ Childhood		
Teen		
Adulthood		

16. What medications are you taking now? Include non-prescription drugs.

Medication Name	Date started	Dosage
1.		

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2.		
3.		
4.		
5.		
6.		
7.		
8.		

Are you allergic to any medications?

Yes\_\_\_\_ No\_\_\_\_

If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate whether mg or IU and the form (e.g., calcium carbonate vs. calcium lactate), when possible.

Vitamin/Mineral/Supplement Name	Date started	Dosage
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

18. Childhood:

Question	Yes	No	Don't Know	Comment
1. Were you a full term baby?				
a. A preemie?				
b. Breast fed?				
c. Bottle fed?				
2. As a child did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?

Yes\_\_\_\_ No\_\_\_\_

If yes, please: name the food and symptom (Example: milk – gas and diarrhea)

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20. Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

	<b>Usual Breakfast</b>	√		<b>Usual Lunch</b>	√		<b>Usual Dinner</b>	√
a.	None		a.	None		a.	None	
b.	Bacon/Sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
	<b>Usual Breakfast</b>	√		<b>Usual Lunch</b>	√		<b>Usual Dinner</b>	√
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other: (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other: (List below)		x.	Yellow vegetables	

						y.	Other: (List below)	

21. How much of the following do you consume each week?

a. Candy	
b. Cheese	
c. Chocolate	
d. Cups of coffee containing caffeine	
e. Cups of decaffeinated coffee or tea	
f. Cups of hot chocolate	
g. Cups of tea containing caffeine	
h. Diet sodas	
i. Ice cream	
j. Salty foods	
k. Slices of white bread (rolls/bagels)	
l. Sodas with caffeine	
m. Sodas without caffeine	

22. Are you on a special diet?

- ovo-lacto                       vegetarian  
 diabetic                          vegan  
 dairy restricted                 blood type diet

Yes \_\_\_ No \_\_\_  
 \_\_\_ other (describe):  
 \_\_\_\_\_  
 \_\_\_\_\_

23. Is there anything special about your diet that we should know? Yes \_\_\_ No \_\_\_

If yes, please explain:

\_\_\_\_\_

—

24. a. Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?

Yes \_\_\_ No \_\_\_

b. If yes, are these symptoms associated with any particular food or supplement(s)?

Yes \_\_\_ No \_\_\_

c. Please name the food or supplement and symptom(s). Example: Milk – gas and diarrhea.

\_\_\_\_\_

\_\_\_\_\_

25. Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? Yes \_\_\_ No \_\_\_



26. Do you feel much **worse** when you eat a lot of :

<input type="checkbox"/> high fat foods	<input type="checkbox"/> refined sugar (junk food)
<input type="checkbox"/> high protein foods	<input type="checkbox"/> fried foods
<input type="checkbox"/> high carbohydrate foods (breads, pastas, potatoes)	<input type="checkbox"/> 1 or 2 alcoholic drinks
	<input type="checkbox"/> other _____

27. Do you feel much **better** when you eat a lot of :

<input type="checkbox"/> high fat foods	<input type="checkbox"/> refined sugar (junk food)
<input type="checkbox"/> high protein foods	<input type="checkbox"/> fried foods
<input type="checkbox"/> high carbohydrate foods (breads, pastas, potatoes)	<input type="checkbox"/> 1 or 2 alcoholic drinks
	<input type="checkbox"/> other _____

28. Does skipping a meal greatly affect your symptoms? Yes \_\_\_ No \_\_\_

29. Have you ever had a food that you craved or really "binged" on over a period of time?

Food craving may be an indicator that you may be allergic to that food. Yes \_\_\_ No \_\_\_  
 If yes, what food(s)? \_\_\_\_\_

30. Do you have an aversion to certain foods? Yes \_\_\_ No \_\_\_  
 If yes, what foods? \_\_\_\_\_

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	b. Color	√
More than 3x/day		Medium brown consistently	
1-3x/day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible.	
1 or fewer x/week		Varies a lot.	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard			

and loose/watery	
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32. Intestinal gas:                       Daily    Present with pain  
     Occasionally    Foul smelling  
     Excessive    Little odor

33. a. Have you ever used alcohol?    Yes  No   
 b. If yes, how often do you now drink alcohol?                       No longer drinking alcohol  
     Average 1-3 drinks per week  
     Average 4-6 drinks per week  
     Average 7-10 drinks per week  
     Average >10 drinks per week

c. Have you ever had a problem with alcohol?                      Yes  No

If yes, please indicate time period (month/year):    from \_\_\_\_\_ to \_\_\_\_\_.

34. Have you ever used recreational drugs?    Yes  No

35. Have you ever used tobacco?    Yes  No   
 If yes, number of years as a nicotine user \_\_\_\_\_,    Amount per day \_\_\_\_\_,    Year quit \_\_\_\_\_.

If yes, what type of nicotine have you used?                       Cigarette     Smokeless  
     Cigar     Pipe     Patch/  
 Gum

36. Are you exposed to second hand smoke regularly?    Yes  No

37. Do you have mercury amalgam fillings?    Yes  No

38. Do you have any artificial joints or implants?    Yes  No

39. Do you feel worse at certain times of the year?    Yes  No   
 If yes, when?                       spring     fall  
     summer     winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home?    Yes   
 No

If yes, which one(s)?                       lead     cadmium  
     arsenic     mercury  
     aluminum

41. Do odors affect you?                      Yes  No

42. How well have things been going for you?

	Very Well	Fair	Poorly	Very Poorly	Does not apply
a. At school					
b. In your job					
c. In your social life					
d. With close friends					

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e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? Yes \_\_\_ No \_\_\_  
 Currently? \_\_\_ Previously? \_\_\_ If previously, from \_\_\_ to \_\_\_\_\_.  
 What kind?

Comments: \_\_\_\_\_  
 \_\_\_\_\_

44. Are you currently, or have you ever been, married? Yes \_\_\_ No \_\_\_  
 If so, when were you married? \_\_\_\_\_ Spouse's occupation \_\_\_\_\_

When were you separated? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you divorced? \_\_\_\_\_ Never \_\_\_\_\_  
 When were you remarried? \_\_\_\_\_ Never \_\_\_\_\_

Spouse's occupation \_\_\_\_\_

Comments: \_\_\_\_\_  
 \_\_\_\_\_

45. Hobbies and leisure activities:

\_\_\_\_\_  
 \_\_\_\_\_

46. Do you exercise regularly? Yes \_\_\_ No \_\_\_  
 If so, how many times a week? \_\_\_\_\_ When you exercise, how long is each session? \_\_\_\_\_

- |                   |                  |
|-------------------|------------------|
| 1. ___ 1x         | 1. ___ ≤15 min   |
| 2. ___ 2x         | 2. ___ 16-30 min |
| 3. ___ 3x         | 3. ___ 31-45 min |
| 4. ___ 4x or more | 4. ___ > 45 min  |

What type of exercise is it?

- |                       |                    |
|-----------------------|--------------------|
| _____ jogging/walking | _____ tennis       |
| _____ basketball      | _____ water sports |
| _____ home aerobics   | _____ other        |

\_\_\_\_\_