Nutritional Questionnaire for Adults

My 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 these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges. **To enhance your scheduled consult time, please have this back to me at least 1 day prior to your appointment, if possible. Please email it to_______________.**

Name: AC Today's date: 8/6/2020

Address: City: State: Zip:

E-mail Address: Fax Number: ( ) -

Home Phone: ( ) - Work: ( ) - Cell: ( ) -

Birthdate: Age: 32 Place of Birth:

Occupation: online fitness coach/part time waitress Referred By: guinea pig Blood Type: i think im blood type A

Height: 5'4 Weight: 130 Sex: F Desired Weight: 130 Last Age at Desired Weight: happy with where i am now

Highest Adult Weight: 145 What Age?: 2017-2018 Lowest Adult Weight: 117 What Age?: 32 and 27

Have you ever dieted?: ☒ Yes ☐ No If Yes, how many times in your adult life? not sure probably more than 5 t o 6

Which diet(s) worked: counting macros, carb cycling, meal plan by a coach,

1. Please check appropriate box:

☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☒ Caucasian ☐ Northern European ☐ Other

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

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a. no libido (been almost 2 yrs)	severe	got fats up, calories up, supp dhea(tested)	not very successful
b. mood swings	severe	started after implants- work on stress	started after implants- work on
c. post nasal drip/sinus issues	severe	4 deviated septum surgery	not successful cant breathe still
d. cold hands	severe	bundle up lol	not successful

3. PAST MEDICAL AND SURGICAL HISTORY:

3. ILLNESSES	WHEN	COMMENTS
a. Anemia (type)		
b. Arthritis		
c. Asthma		
d. Bronchitis	2010?	not sure the year to be exact but young
e. Cancer		
f. Chronic Fatigue Syndrome	2017	happened after implants in sep 2017, also
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel	2008	delt with a lot of gut issues in high school
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Sinusitis	whole life	have had 4 deviated surgeries,
w. Sleep Apnea		not sure but sometimes i think might have i
x. Stroke		
y. Thyroid disease		
z. Other (describe)		
INJURIES		
ab. Back injury		
ac. Broken Bones	2000?	broke nose in middleschool
ad. Head Injury		
ae. Neck Injury		
af. Other (acute) ex: sprained muscle	2006	dislocated right wrist in bad accident
ag. Other (chronic) ex: bad knees	bad back	always get back aches
DIAGNOSTIC STUDIES		
ai . Bone Scan	x ray of nose	when found my nose was broken
aj. CAT Scan		
ak. EKG	2018?	was hosptialized because felt dizzy
al. MRI		
am. Upper/Lower GI Series	2008?/2018	in 2008 ish I had celiac test done, 2018
an. Other (describe)		
OPERATIONS		
ao. Dental Surgery		
ap. Gallbladder		
aq. Hysterectomy		
ar. Tonsillectomy		
as. Other (describe)		had that metal lock and key thing to widden

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)
Maternal side: aunt got breast cancer twice , mom high blood pressure/depression
Paternal side: grandma died of cancer, dad high blood pressure

5. Are your parents living? ☐ No ☒ Yes
If no, comment:

6. Did you have any health issues as a child? ☐ No ☒ Yes - What age? 11 years old, 19 years old
Describe: 11 when i broke my nose in middle school, and 19 years old experienced a lot of bloating issues

7. As a **child,** where there foods you avoided? ☐ No ☒ Yes-(please specify below)

Food	Symptoms
Ex: Milk	Ex: Gas and diarrhea
gluten	bloating, chronic fatigue, irritability
dairy	tried to felt made me bloated more in teenage years

8. Please mark in the chart below with information about recent bowel movements:

Frequency:		**Color:**	
More than 3 times a day	☐	Dark brown	☐
2-3 times a day	☒	Medium brown	☒
One time per day	☐	Very dark or black	☐
4-6 times a week	☐	Greenish	☐
2-3 times a week	☐	Blood is visible	☐
Once or fewer a week	☐	Varies a lot	☐
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	☐		

9. Do you experience intestinal gas? (check all that apply)
☐ present with pain ☐ foul smell ☒ little odor ☐ excessive daily ☒ occasionally

10. Do you experience anal itching? ☐ frequently ☐ occasionally ☐ rarely ☒ never

11. Do you experience any heartburn, chest pressure, or stomach pain? ☐ No ☒ Yes
If yes, do you take anything for relief? (list): no its been more recent though i notice i get heart burn that i never experienecd before

WOMEN ONLY: (Questions 12-21)

12. Have you ever been pregnant? ☐ No ☒ Yes
 If yes, please answer the following:
 a. Number of miscarriages: b. Number of abortions: 1 c. Number of preemies:
 d. Number of term births: e. Birth weight of largest baby: Smallest baby:
 f. Did you develop toxemia? ☒ No ☐ Yes
 g. Have you had any other problems with pregnancy? ☐ No ☐ Yes
 If yes, describe:

13. Age of first mensus: 16?

14. Date of last Pap Smear: 2019 Normal ☐ Abnormal ☒

15. Date of last Mammogram: havent yet Normal ☐ Abnormal ☐

16. Do you currently use contraception? ☐ No ☒ Yes-(type?) sometimes

17. Are you currently taking birth control pills? ☒ No ☐ Yes-(how long?)

 If you're on the pill please comment on physical or mental changes from before taking to now:

18. Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)?
 ☐ No ☒ Yes-(specify) breast tender, water retention and irritabilty , get very bad ovarian cysts around olvulation

19. Have you ever experienced PMS in the past? ☐ No ☒ Yes – When?: before i took bc i used to get bad back pain and break out around cycle its been about 4 years that i stopped bc completely

20. Are you still menstruating? ☒ Yes ☐ No - (age of last period): 32

21. Are you experiencing menopause symptoms? ☒ No ☐ Yes

22. Do you take: ☐ Estrogen ☐ Estrace ☐ Premarin ☐ Other-(specify):

23. **(Men and Women)** Do you have urinary problems? ☐ No ☒ Yes
 If yes, please specify: ☐ Nightly urination ☒ Frequent day time urination ☐ Hesitancy
 ☐ Irregular ☐ Dribbling afterwards ☒ Frequent urge to urinate ☐ Difficulty
 ☒ Feeling of incomplete emptying ☐ Burning sensation

24. **(Men Only):** Do you have prostate swelling? ☐ No ☐ Yes

DENTAL, etc.:

25. Do you have amalgam (silver, black or grey) fillings? ☒ No ☐ Yes (how many?):

26. Have you ever had fillings replaced?
 ☒ No ☐ Yes-(how many? when? with what material?)

27. Do you have root canals? ☒ No ☐ Yes (how many?) Any Problems?

28. Have you had any cavities in the last 2 years? ☒ No ☐ Yes (how many?)

29. Do your gums ever bleed? ☒ No ☐ Yes-(how often?)

30. Do you ever grind your teeth? ☒ No ☐ Yes

31. Do you have any artificial joints or implants anywhere in the body or mouth? ☒ No ☐ Yes

SOCIAL:

32. How well have things been going for you lately?:

	Great	Good	Could be better	Not very good	Does Not Apply
a. school	☐	☒	☐	☐	☐
b. job	☐	☐	☒	☐	☐
c. social life	☒	☐	☐	☐	☐
d. close friends	☒	☐	☐	☐	☐
e. sex	☐	☐	☐	☒	☐
f. your attitude	☐	☐	☒	☐	☐
g. boy/girlfriend	☒	☐	☐	☐	☐
h. children	☐	☐	☐	☐	☒
i. parents	☒	☐	☐	☐	☐
j. spouse	☐	☐	☐	☐	☒

33. With whom do you live? List age of children, if any.
my fiance

34. What is the attitude of those close to you concerning your health?
☒ Supportive ☐ Not supportive ☐ Indifferent

35. Are you currently married, or have you ever been married? ☒ No ☐ Yes
If yes, when: If yes, spouse's occupation:
Have you been separated or divorced? ☒ No ☐ Yes - If yes, when?:

36. What are your hobbies and leisure activities? i love working out, playing tennis , going for walks, reading, going to movies(well before covid)

37. Describe previous jobs/work: i always waitressed, used to work at WIC back in 2018 for one year and half this job made my life very stressful, started online coaching a year ago love it but know functional medicine is my true heart and passion

38. Have you lived outside of the United States? ☒ No ☐ Yes If yes, where/when?

39. What is your total amount of airline trips, in the last year? 1
Estimated total in life: 4 How many out of the country: 2

40. Have **you** experienced any major losses in your life? ☐ No ☒ Yes
If so, please comment: lost a best friend three years ago, in the last two years lost both my grandparents, whom my grandmother i was very close to who passed a year ago

41. Have you or your **family** recently experienced any major life changes (such as a job change)? ☒ No ☐ Yes
If yes, please comment:

42. Have you ever had psychotherapy or counseling? ☐ No ☒ Yes
If yes, what kind? psychiatrist when? back in 2008
Additional comments: only was very short term but did this because had a bad relationship with my dad in childhood that i had issues with intamacy with men

LIFESTYLE:

43. How important is religion (or spirituality) to you?
☐ Not at all important ☒ Somewhat important ☐ Extremely important

44. Do you meditate? ☐ occasionally ☐ often ☒ never

45. How much control do you feel you have over your current state of health? Rate 1-10 (none-all) 5
Comment: i feel theres been a lot going on and my moods up and down and my regular doctors kind of ignore me and feel arent helping me and im sick of not feeling myself

46. How much time have you lost from work or school in the past year due to illness?
☐ 0-2 days ☒ 3-5 days ☐ 6-14 days ☐ more

47. What is your usual bed time? 10-1030 wake time? 7am

48. How well do you sleep? (check all that apply)
☒ Adequate-(sleep through the night) ☐ Wake up feeling well rested
☐ Trouble falling asleep ☐ Wake up still tired
☐ Trouble staying asleep-(How many times do you wake during the night?)

49. Check off typical bedtime activities:
☒ Watch television ☐ Read a book ☐ Listen to music ☐ Bed time snack
☐ Meditate ☐ Bathe/shower ☐ Drink alcohol ☐ Drink caffeinated beverage
☐ Other-(specify):

50. Do you ever need to take a sleep aid? ☐ No ☐ Yes – Which ones at what dose?
How often: i wouldn't say need i like to take magenisum at night and used to take 5htp i tend to have anxiety and ADHD alot

51. Do you exercise regularly now? ☐ No ☒ Yes-(specify): Have you in the past? ☐ No ☒ Yes
☐ Once per week ☐ 2 times per week ☐ 3 times per week ☒ 4 times per week or more
Amount per session: ☐ less than 15 minutes ☐ 15-30 minutes ☒ 30-45 minutes ☐ > 45 minutes
☐ Other-(specify):

52. What type of exercises do you do currently (dog walking does not count)?
☐ Jogging ☒ Walking ☒ Weight training ☐ Water sports ☐ Aerobics ☐ Yoga
☒ Other-(specify): used to hike but havent this year

53. Do you get sun exposure? ☐ No ☒ Yes-(specify): ☐ Daily ☐ Weekly How much? when nice out go for walks 4 times a week

54. Do you wear sun block? ☒ No ☐ Yes-(percentage of time)

ALLERGY & TOXIC POTENTIAL:

55. Do you have any pets or farm animals? ☐ No ☒ Yes - List: lion head rabbit
If yes, where do they live? ☒ Indoors ☐ Outdoors ☐ Both

56. Do odors such as perfume, cleaning solutions, smoke, etc. affect you? ☐ No ☒ Yes
If yes, explain: i feel i have very sensitive skin i get itchy often

57. Have you, to your knowledge, been exposed to toxic metals at your job or at home?
☒ No ☐ Yes: ☐ Lead ☐ Cadmium ☐ Arsenic ☐ Mercury ☐ Aluminum
Explain: not that i am aware of

58. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?
☒ No ☐ Solvents ☐ Paints ☐ Pesticides ☐ Petrochemicals
☐ Coal ☐ Hydrocarbons ☐ Mold ☐ Other (specify): not that i am aware of

59. Do you now or have you recently lived in an older home (pre 1970's)?: ☒ No ☐ Yes
If yes, how old is/was home? How long have/did you live there?

60. Have you ever lived or worked in a water damaged building? ☒ No ☐ Yes
If yes, when? How long?

61. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes?
☒ No ☐ Yes-(explain):
How often do you wear dry cleaned clothing? often

62. Do you have a regular lawn care service? ☒ No ☐ Yes-(how often?)

63. Do you regularly spray for pests outdoors? ☒ No ☐ Yes-(how often?)

64. Do you use bug spray (outside) or insecticides (indoors) on a regular basis? ☐ No ☒ Yes

65. How often are you exposed to burning coal, bonfires, fire pits, etc.? 0

66. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?
☐ No ☐ Yes- Currently: ☐ 1-3 drinks per week ☐ 4-6 ☐ 7-10 ☐ 10 or more
☒ Yes- In the past: ☒ 1-3 drinks per week ☐ 4-6 ☐ 7-10 ☐ 10 or more
If you have quit, when? i gave it up a year ago but had like 2 since than but i do not really enjoy it anymore

67. Have you ever used tobacco? ☐ No ☒ Yes-(specify: in high school) If yes, number of years: 1
Amount per day: 1-2 wasn't a regular thing Year quit? 2008 didn't really inhale

68. Are you now or were you ever regularly exposed to second hand smoke? ☐ No ☒ Yes When? when i was a child my grandmother always smoked

69. Have you ever used recreational drugs? ☐ No ☒ Yes-(specify: used to use a thc pen to help with anxiety and fall asleep but not to get high)

MEDICATIONS:

70. What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

Medication Name	Purpose	Dosage	Start Date
1. fluticasone	post nasal drip	50 mcg	07/23/2020
2.			
3.			
4.			
5.			
6.			

7.			

71. Do you take any other over the counter medications on an **occasional basis**?
If yes, which one(s)? i used to take nyquil a lot when i was kid to sleep better

72. How many times have you taken antibiotics as an infant or child?
☐ Less than 5 times ☒ More than 5 times ☐ More than 10 time ☐ So many times I lost count
Reason: i really don't remmeber my childhood just know as teenager i was on a lot due to sinus infections

73. As an adult, how often do you take antibiotics?
☐ Never ☐ Once a year (on average) ☒ 1-3 times a year (on average)
☐ Longer-(explain):
Why? lyme disease/ sinus issues

74. Were you ever on antibiotics for a prolonged period of time? ☐ No ☒ Yes
If yes, explain: for my lyme disease and as a child/ teenager because i used to get chronic sinus infections

75. Fill in the chart below for how many times you have taken oral steroids (e.g. Cortisone, Prednisone, etc.):

	Less than 5 times	Greater than 5 times	Greater than 10 times
Infancy/Childhood	☒	☐	☐
Teen	☒	☐	☐
Adulthood	☒	☐	☐

76. List all vitamins, minerals, and other nutritional supplements that you are currently taking.
Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

Vitamin/Herbal Supplement(s)	Brand	How Many and When?	Start Date
1. dhea 25	nutrabio	oncer per day 25 mg inam	07/06/2020
2. fish oil	nutrabio	2 per day in am, 2000	1 year?
3. iodine	pure	225 mcg 2x/day	07/06/2020
4. reactive magnesium	nutrabio	2 per day, night , 200 mg	06/2020
5. hydrate (electrolytes)	coffee over cardio	1 scoop	1 year?
6. ashwagandha ksm-66	nutrabio	2 x per day, 600 mg after	07/06/2020
7. green tea extract	nutrabio	1 x per day 500 mg, when	06/2020
8. probiotic	nature bounty	1 per day, 0.5 mg	05/2020
9. vitamin 3	now	once per day 2,000 iu	2 years
10. berberine plus	doctor recommended	1-2 per day 1,200 mg	07/16/2020
11.			
12.			
13.			
14.			

****If you're being seen in person, please bring bottles with you to your appointment****

DIETARY HABITS:

77. Are you currently on a special diet (i.e., vegetarian, South Beach, etc)? ☒ No ☐ Yes
If yes, how long and describe: just countr my macros

78. Usual Breakfast time: 7 Lunch time: 2 Dinner time: 8
Snack time: 11 Snack time: 5 Snack time:

79. Place a mark next to the food/drink that applies to a typical day of your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner	Usual Snacks
None ☐	None ☐	None ☐	None ☐
Cereal ☐	Eat in cafeteria ☐	Pasta ☐	Nuts ☐
Wheat Bran ☐	Eat in restaurant ☐	Potato ☒	Fruit ☐
Oatmeal ☐	Leftovers ☐	Brown rice ☐	Vegetables ☐
Toast ☐	Meat sandwich ☐	White rice ☐	Pretzels ☐
Bagel ☐	Fish sandwich ☐	Beans (legumes) ☐	Potato Chips ☐
Sweet roll ☐	Lettuce (on sandwich) ☐	Fish ☐	Corn Chips ☐
Donut ☐	Tomato ☐	Red Meat ☐	Crackers ☐
Eggs ☐	Salad ☒	Poultry ☒	Cheese ☐
Bacon/Sausage ☐	Salad dressing ☒	Salad ☐	Cookies ☐
Fruit ☒	Soup ☐	Salad dressing ☐	Cake/Pastries ☐
Yogurt ☐	Fruit ☒	Green vegetables ☒	Nut butters ☐
Milk ☐	Yogurt ☐	Carrots ☐	Cereal ☐
Juice ☐	Milk ☐	Yellow vegetables ☒	Ice cream ☐
Tea ☐	Juice ☐	Milk ☐	Trail mix ☐
Coffee ☒	Tea ☐	Juice ☐	Dried fruit ☐
Water ☒	Coffee ☒	Tea ☐	Other: (list) ☐
Butter☐	Water ☒	Coffee ☐	i don’t really snack
Margarine ☐	Regular soda ☐	Water ☒	have 5 smaller
Sugar ☐	Diet soda ☐	Regular soda ☐	
Sweetener ☒	Butter ☐	Diet soda ☐	
Leftovers ☐	Margarine ☐	Butter ☐	
Other: ☒	Mayonnaise ☐	Margarine ☐	
cream rice	Sugar ☐	Sugar ☐	
vegna protein	Sweetener ☒	Sweetener ☐	
natural pb	Other: ☒	Other: ☐	
	olive oil, red wine vinegar	avocado, vegan sour	

80. Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.? ☒ No ☐ Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea)

81. Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*
☐ No ☒ Yes
If yes, specify: i feel i always had sinus issues and post nasal drip, i notice i get afternoon crash usually daily

82. How much of the following do you consume on average?

Food	Amount Per Day	Amount Per Week
Candy	0	0
Cheese	0	0
Chocolate	not everyday	2
Cups of caffeinated coffee	2	14
Cups of decaffeinated coffee	0	0
Cups of hot chocolate	0	0
Cups of tea (containing caffeine)	0	0
Diet sodas (cans)	1	4
Regular soda (cans)	0	0
Ice cream	0	0
Salty snacks	don't snack	
Slices white bread/rolls/1/2 bagel	0	0
Nuts	0	1-2 usually stick to oils, avoacdo for

83. Do you feel **much worse** when you eat any of the following: (check all that apply)

☐ high fat foods ☒ refined sugar (junk foods) ☐ high protein foods ☒ fried foods
☐ high carbohydrate foods ☒ 1 or 2 alcoholic drinks
☐ (breads, pastas, potatoes) ☐ Other (specify):

84. Do you feel **much better** when you eat a lot of: (check all that apply)

☒ high fat foods ☐ refined sugar (junk foods) ☐ high protein foods ☐ fried foods
☒ high carbohydrate foods ☐ 1 or 2 alcoholic drinks
☐ (breads, pastas, potatoes) ☐ Other (specify):

85. Do you feel **worse** at certain times of the year? ☐ No ☒ Yes-(when? midday)
How do you feel? fatigue have energy crashes

86. Do you feel **better** at certain times of the year? ☐ No ☒ Yes-(when? summer/spring/fall)
How do you feel? love warmer weather, depsire winters and the cold

87. Does skipping a meal affect you in any way? ☐ No ☒ Yes – Explain: low blood pressure/sugar

88. Do you ever crave or "binge" on certain foods? ☐ No ☒ Yes
Which foods, how often and comment on possible stressors/triggers? i crave salty foods a lot, i love salt lol, lately i crave soemthing sweet at night so i make concotion of whipped cottage cheese, sf pudding mix, frozen strawerries , unsweetened canned coconut milk, xantham gum

89. Do you avoid certain foods for any reason? ☐ No ☒ Yes
Which foods and why? gluten i got tested celiac negative doctor did genetic test and i had 40% gene for it so i tried gluten free and never felt better, gluten made me feel like i got hit by a bus

Food Frequency List

Please indicate the **approximate number of times** you have eaten these foods in a typical week. For each section you may **check or list** the foods/beverages that you DO eat, and **leave blank** the foods/beverages seldom consumed.

Consumed in the past 7 days	Number of Times	Consumed in the past 7 days	Number of Times
Vegetables: ☒ **Dark green leafy:** ☒ spinach, ☒ Romaine, ☐ leaf lettuce, ☐ Caesar Salad, etc.	7	**Fish: (list): shrimp, frozen** Is it: ☐ fresh, ☐ fried, ☐ canned	3
☒ **Iceberg lettuce** or **bagged salad combos**, ☐ celery, ☐ cucumbers, ☒ zucchini	7	**Poultry: Chicken:** ☐ dark meat, ☒ breast **Turkey:** ☐dark meat,☒breast,☐lunch meat,☐turkey bacon	7
☐ **Broccoli**, ☐ Brussels sprouts, ☒ cabbage/coleslaw, ☐ kale, ☐ turnip or mustard	7	**Beef:** ☐hamburgers, ☐steak, ☐meatloaf, ☐stew, ☐chili Is it usually: ☐ regular, ☒ lean, ☐ grass-fed, or ☐ organic	3
Fresh/frozen **mixed** veggies: ☐ corn, ☐ green beans, ☐ peas	0	**Pork:** ☐ ham, ☐ sausage, ☐ bacon	0
Yellow-orange veg: ☒ carrots, ☐ squash, ☒ sweet potatoes	7	**Hot dogs:** ☐ beef or turkey, ☐ bratwurst, ☐ Italian sausage, etc.	0
☒ **Tomatoes**, ☒ pasta sauce, ☐ tomato juice, ☐ V-8, ☐ salsa, etc	1	**Fried foods:** ☐ fries, ☐ chicken, etc.	0
Fresh vegetable juices (list):	0	☐ **Lunchables®**, ☐ **bologna,** ☐ **salami,** etc.	0
Other (list): **ORGANIC?** Yes	0	**Vegetarian foods (list):**	0
		Indian Vegetarian foods (list):	0
Fruits: ☒banana, ☐pear, ☐apple, ☐grapes, ☐kiwi **Other: avocado pineapple**	7	**Beans, legumes, peas:** ☐ bean/lentil soup, ☒ bean burritos, ☐ veg chili, ☐ split pea soup, etc.	3
Berries (list): rasperbiees , strawberries, blackberries	7	Vegetarian foods (list):	0
Canned/jar fruit: ☐ applesauce, ☐ pears, ☐ peaches	0	☐**Veggie burgers,** ☐**TVP,** ☐**tofu,** ☐**tempeh,** ☐**seitan,** ☐**Quorn® products, etc.**	0
Dried fruits (list):	0	**Raw nuts/seeds:** ☐ almonds, ☐ sunflower seeds, ☐ pecans, ☐ walnuts, etc.	0
Wheat bread: ☐ rolls, ☐ buns, ☐ sandwiches, ☐ pita,☐ bagel, ☐ White, ☐ whole grain, ☐ low carb, ☐ spelt, ☐ Ezekiel®	0	☐ **Trail mix**, ☐ roasted salted nuts	0
Cold cereal (list):	0	☐**Peanuts**, ☒peanut butter, ☐**almond** butter, ☐tahini, etc	7
Hot cereal (list): cream rice	7	**Protein** powders: ☐ **soy,** ☒ **whey,** ☐ **egg or** ☐ **rice?**	7
☐ **Pancakes**, ☐ waffles **Tortillas:** ☐ corn, ☐ flour	0	**Protein:** ☐ liquid (ready-to-drink)	0
☐ **Muffins**, ☐ donuts, ☐ sweet rolls, ☐ granola bars	0	☐ **Flax** seed meal or flax oil, ☐ **cod liver oil**?	0
☐ **Pretzels**, ☐ crackers, etc.	0	☐ **Butter: cant believe not butter spray**	7
Gluten-free foods (list): trader joes gluten free toast	7	☐ **Margarine (list brand):**	0
Rice: ☐white, ☐ brown, ☐ long-grain or wild, ☐ fried	0	☐ **Potato chips**, ☐ Fritos®, ☐ Doritos®, ☐Pringles®, etc.	0
☒ **Potatoes: What kind?** White **Prepared?**	3	**Popcorn:** ☐ **pre-packaged or** ☐ **homemade**	0
Pasta: ☐ spaghetti, ☐ lasagna, ☐ macaroni, ☐ pasta salad, etc.	0	**Candy (list):**	0
		Pie, cake, cookies, other snacks (list):	0
Eggs: ☒ whole, ☒ whites only	7	**Gum**, breath mints: ☐ regular, ☒ sugar-free	4
Dairy: Cow's milk: **what kind?** skim **ORGANIC?** Yes	0	☒ **Coffee/espresso drink?** ☐ regular or ☐ decaf # of 8oz cups? 2	7
☒ **Yogurt**, ☐ **cheese**, ☐ nachos, ☒ cottage cheese **ORGANIC?** No	5	**Tea:** ☐black, ☐green, ☐white, ☐herbal infusion	0
Pizza: ☐ sausage, ☐ pepperoni, ☐ vegetable, etc.	0	**Sugar or no/low calorie sweetener? (list): better stevia**	7
☐ **Ice cream,** ☐ **frozen yogurt**, ☐ shakes/malts, etc.	0	**Soda pop:** ☐**regular or** ☒**diet? (list): diet coke**	3
☐**Soy milk**, ☐**goat** milk, ☐**rice** milk, ☒**almond** milk	3	**Alcohol** beverage: ☐ wine, ☐ beer, ☐ hard liquor	0

Check other frequent foods: Frozen/microwave meals: ☐ Weight Watchers®, ☐ Lean Cuisine®, ☐ Healthy Choice®, ☐ Mexican cuisine, ☐ Indian cuisine, ☐ Chinese/Thai, ☐ Vegetarian, ☐ Atkins®, ☐ Low carb, ☐ SlimFast®, etc.

Average daily water intake in 8 oz glasses (not counting soda pop or coffee): ☐1-2 ☐3-4 ☐5-6 ☐7-8 ☒9-10
Is it: ☐ **tap water,** ☒ **filtered tap water,** ☐ **spring water,** ☐ **distilled, etc.? If filtered, how? brita but learning not real filter**

90. How many times a week do you eat out? 1

Rate the type of restaurants you frequently eat at in order of most to least often (1 being the kind you eat at most often, and 5 for the least often or never):

5 Fast food   1 fine dining   5 café   5 coffee shop or Corner bakery type place

1 Casual dining   4 breakfast dinner   5 grocery store deli   5 health food store deli

91. Are you the primary cook for the household? Yes. If not, who is?

92. On a scale of 1-5, rate what extend you enjoy preparing/cooking food (1 – a lot, 5 – hate it!) 1

93. Where do you do the bulk of your grocery shopping? stop n shop/ trader joes/ big y

94: What percentage of your food intake is Organic? could def be better in this department 10%

95: Do you drink bottled water? No. If yes, appox how many bottles per day?
What size?

Anything else you think we should know? This is the place where you can detail your main concerns and what you expect to get out of working with me: i had breast implants back in 2017 four months after my surgery i experienced a lot of issues like depression (felt suicidal) gut issues, hormonal issues, axiety, mood issues,brain fog, extreme fatigue and so on. Realized it was implants making me sick explanted last april the day after brain fog immedately went away and had so much energy, my eye pupils went white again. Got lyme disease age 23 caught it really quick didn't feel it really impacted my life like some others. Got labs done and have really high b12 and b6 , low iodine, low dhea, ANA positive, i feel so much better since explant but my libido issues really bring concerns and stress to my relationship, i still feel soemthing is off. Last time i felt really well was before my implants. Been having getting really dizzy lately and off balanced - got my eyes checked and fine.