NUTRITION FACTORS

Wellness Questionnaire

Wellness Assessment Questionnaire

First Name _____ Middle Name _____

Last Name _____

Address _____ City _____ State ____ Zip _____

Home Phone ( ) _____-_____

Work Phone ( ) _____-_____

Cell Phone ( ) _____-_____

Email _____

Date of Birth _____ / _____ / _____ Age _____

Marital Status _____

Do you have Children? Yes No Age(s) of Children _____

Are you Pregnant? Yes No

Date of Last Physical _____

Height _____ Weight _____

Blood Pressure _____ BMI _____

Ideal Body Weight ** _____

% Muscle Mass * _____ % Water * _____

% Bone Mass * _____ % Body Fat * _____

** Measured with Body Composition Monitor*

Energy (calorie) Needs ** _____ Protein Needs ** _____

*** Autocalculated at www.nutritionfactors.com/griddiet*

Readiness to Change

Willingness to recognize and make changes are two important steps in the weight loss process. Rate your willingness to make change for each of the behavioral questions listed.

Point System

0 Unwilling
1 Consider it
2 Willing to try
3 Very Willing

	0	1	2	3
Follow a structured eating plan				
Make life changing food choices				
Take expert nutrition advice				
Document your progress each day				
Allow 15 minutes per day to plan menus				
Prepare food ahead of time				
Read all modules				
Engage in physical activities 4-5 times/week				
Chart your measurements on a weekly basis				
Eliminate junk food from your diet				
Will you let someone else plan your menus?				

Medication and Supplement History

List all Medication and Supplement that you take.

Food and supplements can interact with medication. If you are taking any kind of medication, consult your physician before starting this weight loss plan.

Medication / Supplement	Dose	Frequency	How Long

Allergies to Medications, Food or Substances

Personal Wellness History

Mark each of the following symptoms or diseases that you have had in the past 30 days or if you have ever been diagnosed with any of these conditions.

Point Scale

0 Never
1 Occasional
2 1-2 times per week
3 Frequently (4-5 time per week)
4 Constant

Energy Level

	0	1	2	3	4
Fatigue					
Hyperactive					
Lethargic					

Emotional

	0	1	2	3	4
Depression					
Anxiety					
Nervousness					
Irritable					

Head and Eyes

	0	1	2	3	4
Headaches					
Blurry Vision					
Dizziness					
Insomnia					
Irritate, Swollen, Red, or Itchy Eyes					
Hair Loss					
Memory Loss					

Ears

	0	1	2	3	4
Ringing					
Ear Infections					
Earaches					

Nose

	0	1	2	3	4
Stuffy					
Runny					
Sinus Problems					
Allergies					
Mucus					

Mouth and Throat

	0	1	2	3	4
Sore Throat					
Swollen Glands or Tonsils					
Dry Mouth					
Sores					
Swallowing Difficulties					
Choking					
Gum Disease					
Tooth Loss					
Swollen Tongue					

Skin and Body

	0	1	2	3	4
Odor					
Acne					
Dry Skin					
Rashes					
Excessive Sweating					
Hives					

Chest and Lungs

	0	1	2	3	4
Congestion (Chest)					
Asthma					
Shortness of Breath					
Pleurisy					
Lung Cancer					
Smoke					

Endocrine

	0	1	2	3	4
Thyroid Disorder					
Metabolic Syndrome					
Insulin Resistance					

Muscle, Joints, and Ligaments

	0	1	2	3	4
Sore Muscles					
Arthritis					
Loss of Muscle					
Weakness					
Tingling					
Neuropathy					

Physical Activity History

Point Scale

0 Never
1 Rarely
2 1-3 time per month
3 Semi-regular (1-2 time per week)
4 Regular (3-5 times per week)
5 Athlete

How often do you exercise?

0	1	2	3	4	5

List the exercises you participate in.

How often do you cardio (biking, jogging, walking or aerobic classes)?

0	1	2	3	4	5

How often do you do strength training?

0	1	2	3	4	5

How often do you do planned sports?

0	1	2	3	4	5

List any health problems that keep you from being active?

Sleep History

How many hours do you sleep per night? _____

Do you have insomnia? _____

Do you do shift work? _____

Do your legs hurt when you sleep? _____

Do you take sleep aids? _____

Digestive History

Do you take NSAID pain relievers? _____

List any foods that upset your stomach?

How often do you have a bowel movement? _____

Do you have stomach pain? _____

Do you experience constipation? _____

Do you experience diarrhea? _____

Do you take laxatives? _____

Do you have gas or bloating? _____

Do you eat artificial sweeteners? _____

Do you take probiotics? _____

Do you take digestive enzymes? _____

Have you had our microbiome tested? _____

Smoking and Alcohol History

Do you smoke? _____

Do you drink alcohol? _____

Food Assessment

Eating Habits

	Often	Sometimes	Seldom	Never
How often do you eat out?				
How often do you eat on the go?				
Do you stress eat?				
Do you binge eat				
Do you skip breakfast				
Do you substitute shakes for real food?				
How often do you eat pre-packaged foods?				
How often do you prepare your meals?				
Do you live alone?				
Do you cook for others				
How many children live in your household?				
Do you have a spouse or partner?				
Do you snack between meals?				
Do you finish all your food?				
Do you follow a special diet?				
Do you eat fried foods?				

Dietary Assessment

Do you follow any of these specialized diets? Check all that apply:

☐ Low Carb ☐ Low Sodium ☐ Vegetarian ☐ No Dairy

☐ Low Fat ☐ Cardiac ☐ Vegan ☐ Weight Loss

☐ High Protein ☐ Diabetic ☐ Gluten ☐ Free Paleo

How often do you consume each of the following?

Dairy

	Often	Sometimes	Seldom	Never
Skim milk				
Whole milk				
Low-fat yogurt				
Regular yogurt				
Cheese				
Cottage cheese				
Butter				
Margarine				
Sour Cream				

Fruits and Vegetables

	Often	Sometimes	Seldom	Never
Fruits				
Vegetables				

Meats

	Often	Sometimes	Seldom	Never
Chicken				
Turkey				
Beef				
Pork				
Fish				
Processed Meats				
Bacon				
Others				

Grains

	Often	Sometimes	Seldom	Never
Whole Grains				
White Bread				
White Rice				
Brown Rice				
Gluten Free				
Cereals				

Processed Foods

	Often	Sometimes	Seldom	Never
Cookies				
Chips				
Candies				
Desserts				

Beverages

	Often	Sometimes	Seldom	Never
Coffee				
Tea				
Beer				
Liquor				
Soda				
Diet Drinks				
Sugared Drinks				

Artificial Sweeteners / Sweeteners

	Often	Sometimes	Seldom	Never
Aspartame				
Splenda				
Stevia				
Sugar				
Molasses				

Eating Behavior

	Often	Sometimes	Seldom	Never
Emotional Eater				
Snacker				
On-the-Go Eater				
Late Night Eater				
Picky				
Crave salty foods				
Crave sweet foods				
Binge Eater				
Faster				
Social Eater				

List three typical meals

Breakfast:

Lunch:

Dinner:

Environments Assessment

Are you exposed to any harmful toxins or chemicals? _____

Are you exposed to second-hand smoke? _____

Do you use personal hygiene products that contain harmful chemicals? _____

Have you been tested for mold exposure? _____