barbara sobel nutrition
real food, real results

Health Questionnaire

Name: ____ Today's Date:_____________________

Address: ____

City: _______________________________________ State: _____________Zip: __________________

Email address: ________________________________ Skype contact (if applicable): ________________

Home Phone: _________________ Work Phone:_______________ Cell Phone:___________________

What numbers are best for detailed messages? ____

What is your preferred method of contact? ____

How did you find out about Barbara Sobel? ____

Would you like to receive news and recipes from Barbara? _____________________________________

☐ Male ☐ Female DOB: _________________ Place of Birth: _______________________________

Genetic background: ☐ African American ☐ Native American ☐ Mediterranean ☐ Asian

☐ Caucasian ☐ Northern European ☐ Other _____________________

What would you like help with at this time?

1.

2.

3.

4.

Please list your health concerns: **How long have you had these conditions?**

1.____ _________________________________

2.____ _________________________________

3.____ _________________________________

4.____ _________________________________

Medical Information:

What health concerns have you experienced as a child? ____

____

What health concerns have you experienced as an adult? ____

____

Has your doctor diagnosed you with a medical condition (s)? If so, please list: ___________________________

____

Are you part of a recovery program? If so, which one? ____

____

Do you have any allergies to foods, medications, chemicals, and/or other environmental substances?

If so, to which ones and what is your typical reaction and how severe is it (1-10)? ______________________

____

____

Name and contact information for Primary Physician: ___________________________________

____

Please list other practitioners that you are seeing: ____

____

Please attach lab tests from the last year.

Family History:

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		
Children		

Comments on family health history: ____

____

____

Medications and Supplement *Please list all* ***prescription medications*** *and* ***nutritional supplements, herbs*** *you are currently taking. Use a separate sheet if needed.*

Name	Dosage	Frequency	Length of time	Purpose

Have you had prolonged use of any medication in the past (prednisone, acid blocking drugs, Tylenol, antibiotics, etc)? ____

____

List major traumas, major or minor surgeries, and hospitalizations? ________________

____

____

Physical Activity and Lifestyle:

What kind of physical activities do you do? ____

Are you satisfied with your energy level? ____

Are there any problems/limitations that inhibit your physical activity? _____________________________

Activity	Type(s)	Days per week	Duration
Stretching/Yoga			
Strength Training			
Aerobic/Cardio			
Other			

What do you do for relaxation? ____

How many hours of sleep do you get a night/day? ________ Do you sleep well? ____________________

Relationship Status: _______________ # of times Married: ______ Divorced:______ Widowed:______

Current Occupation: _____________________ How many years? _______ Hours per week? _______

Do you like your work? ____

Passions/Interests? ____

On a scale of 1-10, with 1 being low and 10 being high, how stressful is your

Work: ______ Current health status: _______ Social/family situation:_______ Life in general:______

What do you believe you can do to make a difference in your current health? ______________________

____

Environmental information: How often are you exposed to any of the following?

*Insert a number and circle **day** or **week***

Cigarette smoke: _____ x d / wk	How many mercury amalgams do you have? _____
Wood stove: ____ x d / wk	Recreational drugs ____ x d / wk
Perfumes/hair dyes: ____ x d / wk	Pet dander _____ x d / wk
Car exhaust: ____ x d / wk	Mold _____ x d / wk
Pesticides: _____ x d / wk	Cleaning products _____ x d / wk
Dry cleaned clothes _____ x d / wk	Teflon or aluminum pans ____ x d / wk
Bottled water _____ x d / wk	Photo developing/harsh chemicals: _____ x d / wk

Nutrition:

Have you ever had a nutritional consult? ____

Please list **food** allergies: ____

Please list **non-food** and **environmental** allergies: ____________________________________

Please list any special dietary restrictions/habits you have: __________________________________

____

What foods do you crave if anything? ____

What are your favorite foods? ____

Where do you grocery shop? ____

Please describe any changes you have made to your diet to improve your health? _________________

____

How would you describe your relationship to food? _______________________________________

____

Height:_________ Weight: _________ Ideal Weight: _________

Highest Adult weight: _________ Year: _____ Lowest Adult Weight: _________ Year: _____

Food Frequency: How often do you eat or do the following? *Insert a number and circle* ***day*** *or* ***week***

Meals per day: _____

Snacks per day: _____

Water _________ ounces per day

Prepare meals: _____ x d / wk

Nuts/Seeds: _____ x d / wk

Lentils/Beans: _____ x d / wk

Yogurt: _____ x d / wk

Fats and oils: _____ x d / wk *What kinds?*________

Dairy Milk/Cheese: _______x d / wk

Other Milk: _____ x d / wk

Bread: _____ x d / wk

Whole Grains: _____ x d / wk

Pasta: _____ x d / wk

Chips/crackers etc.: _____ x d / wk

Candy: _____ x d / wk

Fast Food: _____ x d / wk

Red Meat: _____ x d / wk

Chicken/Turkey: _____ x d / wk

Deli Meat: _____ x d / wk

Fish: _____ x d / wk

Shellfish: _____ x d / wk

Organ meat: _____ x d / wk

Soy products _____ x d / wk

Eggs: ________ x d / wk

ALL VEGGIES: _____ x d / wk

ALL FRUIT: _____ x d / wk

Coffee: _____ x d / wk, decaf? _________

Herb or other Tea: _____ x d / wk

Soft Drinks: _____ x d / wk, diet OR regular

Frozen Dinners: _____ x d / wk

Alcoholic Drinks: _______ x d / wk

Eat fast or on the run: _______ x d / wk

Symptom Review: Please check symptoms noticed in the past year. Any major problems that you had previously, but no longer have, mark with a "P"

Upper GI

___	Sometimes nausea in evenings	___	Sometimes nausea in mornings
___	Indigestion after eating	___	Sometimes excess salivation
___	Duodenal ulcer	___	Stomach ulcer
___	Sometimes foul burps	___	Strong, demanding hunger
___	Butterflies in stomach	___	Bitter taste or bad breath in morning
___	Seldom eat breakfast	___	Acid indigestion at night
___	Often don't' finish meals	___	Frequent mouth or cold sores, or receding gums
___	Often eat to calm down	___	Mouth frequently too dry, or difficulty swallowing
___	Frequent use of alcohol	____	Frequent poor appetite

Lower GI

___	Tongue often coated	___	Stools loose with gas
___	Frequent constipation, need for laxatives	___	Digestion unusually rapid
___	Light colored, hard stools	___	Loose stools when tired/stressed
___	Intestines often bloated, or gassy	___	Dark, soft stools
___	Constipation with hemorrhoids or pain	___	Quick defecation after eating
___	Constipation with hard, marble like stools	____	Alternating constipation / diarrhea

Liver and Gallbladder

___	Dry, even scaly skin	___	Moist, sometimes oily skin
___	Hay fever or asthma	___	Hives from food or drugs
___	Craves fruit or sweet	___	Craves protein, fats
___	Frequent trouble digesting fats	___	Fever with sweat when sick
___	Acne on face AND buttocks	___	Frequent minor illnesses, don't sweat
___	Seem to have low blood sugar	___	Psoriasis, eczema, dermatitis
___	Had hepatitis in past	___	Frequent use of alcohol or chemicals/solvents

Renal and Urinary

___	Standing quickly causes faintness or dizziness	___	Standing quickly makes pulse roar in ears
___	Frequent flushing or blushing	___	Frequent water retention
___	Moderate low blood pressure	___	Urine usually dark
___	Frequent thirst	___	Moderate high blood pressure
___	Craving for salt	___	Infrequent urination, copious urine
___	Urine always light colored	___	Frequent or urgent urination, small amounts
___	Dull ache or dribble after urination	___	Mucus in urine
___	Frequent bladder infections		

Cardiovascular and Lymph

___	Fast, light pulse	___	Slow, strong pulse
___	Cold bodied	___	Frequent physical activity
___	Sometime dizzy or faint	___	Warm bodied
___	Hands cold, clammy or dry	___	Hands warm, sweaty
___	Hypertension, not responding to diuretics	___	Palpitations as an adolescent or before menses
___	Injuries/Colds heal slowly	___	Hypertension, responds to diuretics
___	Cold hands and feet	___	Injuries/Colds heal quickly

Male Reproductive

__	Difficult maintaining erection	___	Benign prostatic hypertrophy
__	Pain or ache after orgasm		Are you sexually active? ______________________

Female Reproductive

__	Cycle more than 28 days	___	Cycle less than 28 days
__	Miss some periods	___	Water retention before menses
__	Menses slow starting with cramps	___	Constipation before, loose stools after menses start
__	Menstruation always lengthy	___	Always hungry before menses
__	Abnormal Pap Smear	___	Breast tender before menses
__	History of PID, cervicitis	___	Palpitations before menses
__	Miscarriages, problem pregnancy	___	**Number of Children/Live Births**
__	Tried, couldn't take birth control pills	___	**Any chance you may be or may try to get pregnant?**

Date of Last Menses________________________

Are you sexually active? _________________Birth Control Method ______________________

Respiratory

___	Shortness of breath when standing or walking	___	Easy coughing of mucus
___	Tobacco smoker	___	Sometimes hyperventilates
___	Difficulty swallowing	___	Yawns frequently
___	Difficulty coughing up mucus	___	Frequent chest colds
___	Rapid, shallow breather	___	Sometimes wake up choking or gasping for breath

Muscle and Skin

___	Dry scalp or hair	___	Oily scalp or hair
___	Lips often dry and chapped	___	Sweat freely with strong scent
___	Food causes distress as it passes through	___	Oily skin, facial acne
___	Sores, cracks, fissures in mouth, vagina or anus	___	Cracks, fissures on heel, elbow, feet, poorly healing
___	Skin eruptions are deep, not coming to a head		

General

Mark "1" if somewhat applies. Mark "2" if strongly applies.

__ Aluminum cooking vessels
__ Awakens, can't go back to sleep
__ Bad dreams
__ Blurred vision
__ Brown spots, bronzing of skin
__ Bruises easily
__ Can't gain weight
__ Can't lose weight
__ Can't get started without coffee
__ Chemical or spray poisoning
__ Chronic fatigue, depression
__ Cry easily without seeming cause
__ Depressed for long periods
__ Earaches
__ Eat often or else faint/nervous
__ Eyes often red or inflamed
__ Face, eyes get puffy
__ Facial twitches
__ Gum problems
__ Headaches
__ Headaches in morning, wearing off
__ Heart palpitations after eating
__ Highly emotional
__ Highly controlled
__ Impaired hearing
__ Increase in weight (recent)
__ Lack of sensation somewhere
__ Likes depressants
__ Likes stimulants
__ Lower back pain
__ Muscle cramps
__ Nails split, brittle
__ Nails weak, ridges
__ Nosebleeds frequently
__ Pollution heavy in environment
__ Ringing in ears
__ Pulse speeds up after meals
__ Sensitive to cold weather
__ Sensitive to hot weather
__ Sensitive to high humidity
__ Sensitive to low humidity
__ Sexual desire decreased
__ Sexual desire increased
__ Stuffy nose during the day
__ Stuffy nose in evening or night
__ Tendency to anemia
__ Tremors in hands or neck
__ Varicose veins
__ Weight gain in upper arms, shoulders, back of neck

NUTRITION: 3-Day Food Diary

1) Please write down all food and drink, including water
2) Record information as soon as possible after the food has been consumed
3) Do not change your eating behavior, the purpose of this food record is to analyze your current eating habits.
4) Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
5) Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.

Day 1	Day 2	Day 3
Breakfast	Breakfast	Breakfast
Snack	Snack	Snack
Lunch	Lunch	Lunch
Snack	Snack	Snack
Dinner	Dinner	Dinner
Snack	Snack	Snack