



# Stress Consult: Functional Nutritional Questionnaire

Name \_\_\_\_\_ Sex \_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

What would you like to see differently in your health: You can indicate more than one, number according to priority

- |                        |                       |        |
|------------------------|-----------------------|--------|
| More energy            | Better Mood           |        |
| Weight Loss            | Less anxiety/ tension |        |
| Digestive help         | Improved sleep        | Other: |
| Stronger Immune system | Hormonal help         |        |

Health Concerns or Conditions you are being treated for at present. List medications:

Condition	Medication
1.	
2.	
3.	
4.	
5.	
6.	

## Diet

Indicate frequency per week of following items you consume:

- |                             |                             |                      |
|-----------------------------|-----------------------------|----------------------|
| Alcohol                     | Tap Water # glasses per day | Hot dogs/ Deli meats |
| Fast Food 1x day; 5-7x week | Coffee # cups per day       | Fried Foods          |
| Candy                       | Refined Flour               | Soft Drinks          |
| Cigarettes                  | Well Water depth of well    | Vegan                |
| Chewing Tobacco             | Supplements # times per day | Vegetarian           |
| Cigars                      | Dieting how often           |                      |
| Coffee                      | Non herbal tea              |                      |
| Margarine                   |                             |                      |

## Lifestyle

- Exercise: # times per week  
 Changed jobs: within last month  
 Divorce: within last year  
 Relationship stress: children, spouse, partner  
 Work over 50 hours or 2 jobs: 4 usually 3 part of the month 2 seasonal 1 rarely

## Beliefs and Values

What we think about and belief sets the tone for our health. What do you believe about your health?

I am a well person who has a challenge

I am a sick person who needs to get well

Fill in the blank: If I did not have this problem... I could...

- Values: What is most important to you. Chose 5. Family Security Career Money Love Helping  
 Others Character Belonging Health Inspiration God Other:



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**Instructions: Read the following questions, rate each based on the number that applies:**

**0 = Do not have the symptom, the symptom does not apply**

**1 = rarely occurs**

**2 = occasionally occurs**

**3 = frequently occurs**

**4 = aware of it almost constantly**

## Digestion

- |  |   |
|--|---|
| 1. _____ Belching or gas within 1 hr. of a meal                                | 8. _____ Alternating constipation/diarrhea            |
| 2. _____ Distaste for meat (not a vegetarian for moral other or other reasons) | 9. _____ Nausea                                       |
| 3. _____ Fewer than one bowel movement per day                                 | 10. _____ Burning top of stomach/ gastric reflux      |
| 4. _____ Stools hard or difficult to pass                                      | 11. _____ Coated tongue                               |
| 5. _____ Bloating after eating   | 12. _____ Lactose intolerant                          |
| 6. _____ Only specific foods cause bloating                                    | 13. _____ Colitis, irritable bowel or Crohn's disease |
| 7. _____ Lower bowel gas   | 14. _____ Binge eating or uncontrolled eating         |

## Lifestyle

- |  |  |
|--|--|
| 15. _____ Sleepy after eating (eating too fast, processed food)        | 20. _____ Is your low mood with a strong desire to sleep, sleeping a lot and having trouble getting out of bed |
| 16. _____ Sinusitis (nose stuffy, sinus headaches or sinus infections) | 21. _____ Do you feel agitated, anxious or having difficulty falling and staying asleep                        |
| 17. _____ Runny or drippy nose   | 22. _____ Lack of motivation (function from day to day but lacking initiative)                                 |
| 18. _____ Catch colds at the beginning of winter                       |  |
| 19. _____ Low mood   |  |

## Liver/Gallbladder

- |   |  |
|---|--|
| 23. _____ Sensitive to smoke  | 29. Are you a recovering alcoholic? # Years                  |
| 24. _____ Become sick after drinking wine (as opposed to other alcoholic beverages) | 30. _____  |
| 25. _____ Urine has a strong odor   | 31. _____ Pain between the shoulder blades (GB)              |
| 26. _____ Trouble tolerating garlic or onions                                       | 32. _____ Bitter taste in mouth, especially after meals (GB) |
| 27. _____ Sensitive to chemicals (perfume, insecticides, exhaust fumes)             | 33. _____ Trouble tolerating greasy foods                    |
| 28. _____ Sweat a lot   | 34. _____ Gallbladder attacks (past or present)              |

## Sugar Cravings (Yeast/Candida)

- |  |  |
|--|--|
| 35. _____ Crave sugar  | course < 2 mo.; 2 = 1 course 2 mo. or longer; 3 = 2x in a single year; 4 = more than 2x in a single year)    |
| 36. _____ Eat dessert (4 if 5x week. Include dessert during the day; after any meal)                     |  |
| 37. _____ Crave bread or noodles   | 41. _____ Feel worse when in a moldy or musty place  |
| 38. _____ Eat refined white flour products   | 42. _____ Taken birth control pills (1= 6 mos. or less ; 2= 1 yr. or less; 3= 1-2 yrs.; 4= more than 2 yrs.) |
| 39. _____ Have you taken antibiotics for acne? [1 = 1 mo.; 2 = 2 mo.; 3 = 3 mo.; 4 = 4 mo. or longer]    | 43. _____ Fungus or yeast infections   |
| 40. _____ Have you taken broad-spectrum antibiotics for urinary, respiratory or other infection? ( 1 = 1 |  |



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### Detox

- 44. \_\_\_\_\_ Feeling “wired” or jittery if drinking coffee
- 45. \_\_\_\_\_ Bizarre, vivid or nightmarish dreams (B6)
- 46. \_\_\_\_\_ Metallic taste in the mouth
- 47. \_\_\_\_\_ Wake up without remembering dreams (B6)
- 48. \_\_\_\_\_ Bothered if eating food with monosodium glutamate (MSG)
- 49. \_\_\_\_\_ Become intoxicated easily if drinking alcohol
- 50. \_\_\_\_\_ Severe hangovers after drinking alcohol
- 51. \_\_\_\_\_ Trouble tolerating aspartame (NutraSweet)
- 52. \_\_\_\_\_ Sweat at night (hormones)

### Blood Sugar (high or low)

- 54. \_\_\_\_\_ Migraine headaches
- 55. \_\_\_\_\_ Crave coffee or sugar in the afternoon
- 56. \_\_\_\_\_ Afternoon headaches
- 57. \_\_\_\_\_ Fatigue that is relieved by eating
- 58. \_\_\_\_\_ Shaky, headachy, or tired when meals are delayed
- 59. \_\_\_\_\_ Family history of diabetes (1 = distant relative; 2 = 1 or 2 direct relatives; 3 = 3 or 4 direct relatives; 4 = more than 4 direct relatives)
- 60. \_\_\_\_\_ Frequent thirst
- 61. \_\_\_\_\_ Cuts take a long time to heal
- 62. \_\_\_\_\_ Frequent urination
- 63. \_\_\_\_\_ Frequent infections
- 64. \_\_\_\_\_ Numbness or tingling in the extremities

### Essential Fatty Acids/Inflammation

- 65. \_\_\_\_\_ Dry flaky skin or dandruff
- 66. \_\_\_\_\_ Take over the counter pain medication (depletes glutathione)
- 67. \_\_\_\_\_ Patches of dry skin, eczema or psoriasis
- 68. \_\_\_\_\_ Crave greasy or fatty foods
- 69. \_\_\_\_\_ Muscles become easily fatigued

### Minerals

- 70. \_\_\_\_\_ Fingernails chip, peel or break easily
- 71. \_\_\_\_\_ Feet have a strong odor or sweat easily
- 72. \_\_\_\_\_ Heart races or palpitates (rule out cardiac disease with MD)
- 73. \_\_\_\_\_ Decreased ability to taste or smell
- 74. \_\_\_\_\_ Calves cramp at night

### Thyroid Support

- 75. \_\_\_\_\_
- 76. Hair breaks or falls out easily
- 77. \_\_\_\_\_ Cry, become teary or sad for no reason
- 78. \_\_\_\_\_ Become cold easily or when others are not
- 79. \_\_\_\_\_ Brittle, coarse hair
- 80. \_\_\_\_\_ Difficulty losing weight
- 81. \_\_\_\_\_ Frequent colds or the flu
- 82. \_\_\_\_\_ Frequent diets (reducing food intake) (1=1 or 2; 2=3 or 4; 3 = 5 or 6; 4 = 7 or more)
- 83. \_\_\_\_\_ Exercise makes you feel worse



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### Hidden Food Sensitivities/ Adrenal Fatigue

84. \_\_\_\_ Are there any foods that you feel that you would not want to give up?
85. \_\_\_\_ Hay fever or seasonal allergies
86. \_\_\_\_ Asthma, wheezing or difficulty breathing
87. \_\_\_\_ Fatigue (Are you getting enough sleep? Yes/No)
88. \_\_\_\_ Crave salt or salty foods
89. \_\_\_\_ Become dizzy when standing up suddenly
90. \_\_\_\_ Trouble getting out of bed in the morning
91. \_\_\_\_ Tend to be a "night" person
92. \_\_\_\_ Tendency to worry
93. \_\_\_\_ Tend to be calm on the outside, troubled inside
94. \_\_\_\_ Keyed up, trouble calming down.
95. \_\_\_\_ Fall asleep only to wake up after a few hours and have trouble falling back to sleep
96. \_\_\_\_ Difficulty falling asleep
97. \_\_\_\_ Get hives
98. \_\_\_\_ Acne
99. \_\_\_\_ Dark circles under the eyes

### Women's Health

100. \_\_\_\_ Anxiety, irritability, emotional instability related to menstrual cycle
101. \_\_\_\_ Depression during period
102. \_\_\_\_ Weight gain greater than 3 pounds and/or abdominal bloating associated with cycle
103. \_\_\_\_ Breast tenderness, soreness or swelling associated with cycle
104. \_\_\_\_ Excess menstrual flow
105. \_\_\_\_ Sugar, chocolate, or carbohydrate craving associated with cycle

### Men's Health

106. \_\_\_\_ Dribble after voiding urine
107. \_\_\_\_ Frequent urination or urgency to urinate
110. \_\_\_\_
108. \_\_\_\_ Interruption of the stream during urination
109. \_\_\_\_ Wakes up at night - # of times:

### Vitamin Need

111. \_\_\_\_ Pain or swelling in the joints
112. \_\_\_\_ Hands tremble (Riboflavin, Niacin)
112. \_\_\_\_ Heart races
113. \_\_\_\_ Reacts to insect bites

### Comments: