Name:_____ Date:_____

LIFE STYLE AND NUTRITION

"Let thy food be thy medicine and thy medicine be thy food" ~ Hippocrates

Naturopathic care is only possible when the physician has a complete picture of the patient physically, mentally, and emotionally. Therefore, please take the time to carefully and thoroughly complete this lifestyle and nutrition questionnaire. Although some questions may seem redundant, all of this information is vital to ensuring we are aware of you, your body and your lifestyle, allowing us to customize a healing protocol specifically for you.

1. Do you have a regular eating habit? Y___N___
2. Do you usually feel hurried for your meals? Y___N___
3. Do you snack? Y___N___
4. Do you crave for certain taste or foods? Y___N___

   If yes, what do you crave? _____
5. Which of the following do you consume regularly?

   Caffeine _____ Sugar _____ Dairy products _____

   Fatty food _____ Salty food _____ Cold raw food _____
6. Do you tend to eat under stress or when you are depressed? _____
7. Do you exercise regularly? Y___N___
8. What do you do to exercise? _____
9. Do you normally get enough sleep at night? Y___N___
10. How many hours do you normally get each night? _____
11. How is the quality of your sleep? _____
12. Do you dream a lot? Y___N___

    If yes, do your dreams bother you? Y___N___
13. Are you constantly under stress? Y___N___
14. How do you manage your stress? _____

15. <u>What Type of Cooking Oils do you use?</u> (check all that apply)

__Vegetable
__Olive
__Corn
__Butter
__Margarine
__Other:_____

16. <u>How do you prefer to heat your food?</u> (Mark the most common)

__Oven
__Stove-Top
__Microwave
__Toaster Oven

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17. Please check all of the following which apply to you:

__Vegetarian
If yes: Do you eat A) Dairy B) Fish C) Eggs
__Vegan
__Kosher
__Macrobiotic
__High Protein/Low Carb
__Gluten Free

18. Food Allergies (check all that apply)
__None
__Whey
__Eggs
__Wheat
__Lactose intolerance
__Shellfish, Seafood
__Beef
__Lamb
__Pork
__Fruits, please specify: _____
__Tree Nuts and/or peanuts, please specify: _____
__Spices, please specify: _____
__Other, please specify: _____

What happens when you have an "allergy attack"? _____

19. Dietary preferences (Please mark all that apply)

___ Vegetarian
___ Vegan
___ Raw foods diet
___ Low fat diet
___ High protein/low carb
___ Dairy /milk /cheese
___ Eggs
___ Chicken
___ Fish / seafood
___ Red meat
___ Artificial sweeteners (Equal, Sweet & Low, Splenda, etc.)

___ Fast food/ burgers/fries
___ Spicy / hot
___ Sweet
___ Sour
___ Salty
___ Cold drinks
___ Hot drinks
___ Ice chewing
___ Extreme thirst
___ Thirst with no desire to drink

20. Do you need snacks between meals? Yes / No

If yes, more at what time of day? Mid-morning/ Mid Day/After Dinner

Favorite snacks: _____i.e. chips, candy, fruit, pastries, etc.

21. Do you drink soda pop? Yes / No
    Type & amount desired per day: _____

22. Do you eat desserts? Circle whichever applies
    Gotta have sweets! / Take it or Leave it / I don't like sweets!

23. Beverages:

    Water? Yes / No
    If yes, how many glasses per day?_____

    (Please circle all that apply) **B**=Breakfast/**L**= Lunch/**D**=Dinner

Coffee	B	L	D	# per day_____
Decaf	B	L	D	# per day_____
Iced Tea	B	L	D	# per day_____
Hot Tea	B	L	D	# per day_____
Juice	B	L	D	# per day_____Type:_____e.g. Orange
Alcohol	B	L	D	# per day_____Type:_____e.g. Wine

PLEASE WRITE DOWN EVERYTHING YOU EAT FOR TWO DAYS PRIOR TO YOUR APPOINTMENT

DAY 1:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

*Dessert:*_____

DAY 2:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

*Dessert:*_____