

# Pure Love Living Foods

## NUTRITION CONSULTATION

### Questionnaire

Please print your name \_\_\_\_\_ Date \_\_\_\_\_

Pure Love Living appointments are very in-depth and personalized. For this reason we have prepared an extensive questionnaire for you to fill out. Please read the following prior to filling out the questionnaire and send it in as soon as possible.

We recommend that you take your time in filling out this questionnaire. For the food frequency part of the questionnaire, please pay close attention to the serving sizes listed. For instance, if the serving size for pasta is 1/2 cup and you eat 2 cups three times per week, you will need to enter 12 in the weekly column (only choose one column, the one that most closely matches your intake of the food). You don't need to be exact, but try to be as accurate as possible, so that the questionnaire will reflect an average of your daily intake.

The more information you provide, the more assistance we will have to base your initial recommendations. If you consume any foods on a regular basis that you do not see listed, please add those at the end, i.e., pretzels, protein drinks, french fries, etc. Also note when a food is different from it's listing, i.e. fat free, low fat, etc.

#### **Please bring to your visit:**

- ***A list of any medications and/or vitamin or herbal supplements that you currently take, even better---bring the actual bottles.***
- ***A written sample of your "typical day" of eating/drinking-noting times of the day you eat as well.***
- ***Please obtain a copy of any recent blood work, labs, etc. and bring them with you to the visit (or have them sent with your initial paperwork).***

Since this appointment is very in-depth and personalized, we reserve the right to cancel or reschedule your appointment if we have not received this questionnaire either by E-mail ( [linda@purelovelivingfoods.com](mailto:linda@purelovelivingfoods.com) ) within 48 hours prior to your scheduled appointment.

Or send to:

Pure Love Living Foods  
13170 Papercraft Avenue  
Weeki Wachee, FL 34614

**\*\*\*Please allow enough mail time (1 week) for delivery.**

*\*\*You will also be assessed a fee for failing to keep this appointment without proper notification of cancellation within 24 hours which is 50% of the initial consultation.*

*If you are having difficulty with the questionnaire, please do not hesitate to call (352) 397-5531.*

*Please note: Insurance plans do not cover this service. You will be expected to pay at the time of your visit.*

**We look forward to working with you and helping you to reach optimal health!**

## HEALTH QUESTIONNAIRE

Please write clearly and answer the questions as accurately as possible as this will help your treatment. All information given will be treated as strictly confidential.

### General information

Name \_\_\_\_\_ Title \_\_\_\_\_

Tel. No \_\_\_\_\_ Mobile \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zipcode \_\_\_\_\_ E-mail \_\_\_\_\_

Marital status \_\_\_\_\_ Date of birth \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Occupation \_\_\_\_\_

Does your doctor know that you plan to see a nutritional therapist? Yes / no

Doctor's name & address \_\_\_\_\_

Health concerns \_\_\_\_\_

What event, food, environment, exercise etc has an impact on your symptoms? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Which aspects of your health would you most like to improve?

Please list any associated symptoms

Acts as a trigger \_\_\_\_\_ Makes things worse \_\_\_\_\_ Makes things better \_\_\_\_\_

1.

2.

3.

Please explain briefly what you would like to achieve from this consultation \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Personal medical history

What types of therapy have you tried: (circle one)

diet modification . fasting . vitamin/mineral . herbs . homeopathy . chiropractic . acupuncture .

conventional drugs . Other \_\_\_\_\_

List current health problems for which you are being treated: \_\_\_\_\_

Have you received a diagnosis for any of your health concerns from a medical doctor? Y/N

(if yes, please specify) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Personal History (continued )**

If yes, have you received any conventional treatment/medication/tests? Y/N  
(please provide test results if available)\_\_\_\_\_

Please give details of all current medication:  
(include name of medication and daily dosage)\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Have you taken any antibiotics recently? Y/N  
(if yes, please specify when and for how long)\_\_\_\_\_

Have you undergone any operations or suffered from any serious illness? Y/N  
(if yes, please specify)\_\_\_\_\_

\_\_\_\_\_

**Family Medical History**

What if any illnesses/health conditions are present on your mother's/father's side of family?  
(e.g. heart disease/cancer/obesity/allergies etc.)

Mothers side:\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Fathers Side\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Nutritional Supplements**

Are you currently taking any nutritional supplements? Y/N  
(if yes, please specify name, daily dosage and reasons for taking them)\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Health Profile**

Please rate the symptoms listed below: **0 = never, 1 = mild/occasional, 2 = severe/frequently**

Constipation \_\_\_\_\_ Indigestion \_\_\_\_\_ Nausea \_\_\_\_\_ Diarrhea \_\_\_\_\_

Heartburn \_\_\_\_\_ Anal irritation \_\_\_\_\_ Bloating feeling \_\_\_\_\_

Flatulence/passing wind \_\_\_\_\_ Burning sensation in stomach \_\_\_\_\_

Nausea or bloating after eating fatty foods \_\_\_\_\_

Pain in liver area (right side under rib cage) \_\_\_\_\_

Dark circles under eyes \_\_\_\_\_

Do you have a bowel movement daily? \_\_\_\_\_

Do you skip meals? \_\_\_\_\_

Do you eat quickly and in a rush or eat on the move? \_\_\_\_\_

How would you describe your appetite? \_\_\_\_\_

Recurrent colds & infections \_\_\_\_\_

Asthma \_\_\_\_\_ Dark circles under eyes \_\_\_\_\_

Cold sores \_\_\_\_\_ Eczema \_\_\_\_\_ Itchy or sore throat \_\_\_\_\_

Nasal congestion/stuffy nose \_\_\_\_\_ Hay fever \_\_\_\_\_

Poor wound healing \_\_\_\_\_

Muscle/joint pains \_\_\_\_\_

Where? \_\_\_\_\_

Arthritis or rheumatism \_\_\_\_\_ Feeling weak/tired \_\_\_\_\_

Do you find it difficult to shake off an infection? \_\_\_\_\_

Do you get more than 3 colds per year? \_\_\_\_\_

Please state any allergies/sensitivities you may have: \_\_\_\_\_

Are you prone to thrush or cystitis? \_\_\_\_\_

Do you smoke or are an ex-smoker? Y/N  
(please state average per day) \_\_\_\_\_

Do you bruise easily? \_\_\_\_\_

Excessively tired \_\_\_\_\_ Feeling lethargic \_\_\_\_\_ Cold hands & feet \_\_\_\_\_

Poor concentration \_\_\_\_\_ Nervousness/anxiety \_\_\_\_\_

Unexplained weight gain \_\_\_\_\_ Loss of appetite \_\_\_\_\_ Depression \_\_\_\_\_

Difficulty gaining or losing weight \_\_\_\_\_ Poor short term memory \_\_\_\_\_

Headaches/migraine \_\_\_\_\_ Heartburn \_\_\_\_\_

Do you have cravings for sweet or starchy foods? \_\_\_\_\_

Do you experience drowsiness during the day? \_\_\_\_\_

Do you experience mood swings? \_\_\_\_\_

Are you slow to wake up in the morning? \_\_\_\_\_

Do you get irritable if you go without food for more than 3 hours? \_\_\_\_\_

Do you sometimes find it difficult to stop eating? \_\_\_\_\_

Do you experience excessive sweating or thirst? \_\_\_\_\_

Acne \_\_\_\_\_ Greasy skin \_\_\_\_\_ Cracked lips \_\_\_\_\_ Eczema \_\_\_\_\_

Breaking/splitting nails \_\_\_\_\_ White spots on nails \_\_\_\_\_ Psoriasis \_\_\_\_\_

Dandruff \_\_\_\_\_ Slow wound healing \_\_\_\_\_ Dry/scaly skin \_\_\_\_\_

Itchy skin \_\_\_\_\_ Dry eyes \_\_\_\_\_

Do you live on a busy road or in a town or city? \_\_\_\_\_

**Health Profile (continued)**

Do you live near cell phone towers? \_\_\_\_\_

Do you eat organic food? \_\_\_\_\_

Do you live in an old house with copper pipes? \_\_\_\_\_

Do you have amalgam (heavy metal) fillings? \_\_\_\_\_

Do you use aluminum cookware? \_\_\_\_\_

Do you cook in your microwave? \_\_\_\_\_

Do you eat canned foods frequently? \_\_\_\_\_

Do you eat out frequently? \_\_\_\_\_ x weekly \_\_\_\_\_

Do you eat Fast Food frequently? \_\_\_\_\_ x weekly \_\_\_\_\_

Do exercise regularly? Y/N  
(please specify) \_\_\_\_\_

Would you describe yourself as: (circle one)

**a)** very active **b)** active **c)** moderately active **d)** sedentary

On a scale of 1-10 with 10 being the highest, how would you rate your current stress levels? \_\_\_\_\_

Comments \_\_\_\_\_

Are there any issues that make you feel stressed at the moment (e.g major life change: new job, parenthood, moving house, looking after elderly relative)? \_\_\_\_\_

Do you find it hard to relax? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

Do you often feel rushed/edgy? \_\_\_\_\_

Do you have a difficult time getting to sleep? \_\_\_\_\_

Do you wake up in the night? \_\_\_\_\_

How many hours sleep do you usually get? \_\_\_\_\_

Do you feel un-refreshed on waking? \_\_\_\_\_

**Female only profile**

Please rate the symptoms listed below: **0 = never, 1 = mild/occasional, 2 = severe/frequently**

Cyclical mood swings \_\_\_\_\_ Irregular periods \_\_\_\_\_ Menstrual cramps \_\_\_\_\_

Depression \_\_\_\_\_ Heavy periods \_\_\_\_\_ Sugar cravings before a period \_\_\_\_\_

Salt cravings before a period? \_\_\_\_\_ Water retention \_\_\_\_\_ Painful periods \_\_\_\_\_

Pre-menstrual bloating \_\_\_\_\_ Breast tenderness \_\_\_\_\_ Headaches/migraine \_\_\_\_\_

Spotting \_\_\_\_\_ Mood flare-ups \_\_\_\_\_

**Female Profile (continued)**

Pre-menopausal: Y/N

Days between last 6 menstrual cycles \_\_\_\_\_

\_\_\_\_\_

Which method of contraception do you use? \_\_\_\_\_

Are you pregnant or planning to become pregnant? \_\_\_\_\_

Post-menopausal: \_\_\_\_\_ How Long since last period? \_\_\_\_\_

Do you experience hot flushes? \_\_\_\_\_

Do you experience vaginal dryness? \_\_\_\_\_

Do you experience night sweats? \_\_\_\_\_

Have you taken or are currently taking HRT? \_\_\_\_\_

Have you had a bone scan? \_\_\_\_\_

**Male only profile**

Please rate the symptoms listed below: **0 = never, 1 = mild/occasional, 2 = severe/frequently**

Mood swings \_\_\_\_\_ Frequent urination \_\_\_\_\_ Loss of motivation & drive \_\_\_\_\_

Depression \_\_\_\_\_ Difficulty urinating \_\_\_\_\_

Difficulty maintaining an erection \_\_\_\_\_ Loss of libido \_\_\_\_\_ Low sperm count \_\_\_\_\_

**Dietary habits**

Do you have any special dietary requirements, e.g. vegetarian, vegan, gluten-free etc? Y/N

(please specify) \_\_\_\_\_

\_\_\_\_\_

How many portions of vegetable/salad (excluding potatoes) do you typically eat each day? \_\_\_\_\_

Kinds of vegetables? \_\_\_\_\_

Have you ever been on or are currently on any specific diet? Y/N

(please specify) \_\_\_\_\_

\_\_\_\_\_

How many portions of fruit (including dried fruit and fruit juice) do you typically eat each day? \_\_\_\_\_

Kinds of fruit? \_\_\_\_\_

How many times a week do you consume ready made meals? \_\_\_\_\_

How many portions of carbohydrate do you eat each day? (e.g. cereals, bread, pasta, rice and potatoes) \_\_\_\_\_

How many times a week do you eat out? \_\_\_\_\_

Do you eat wholegrain bread/pasta/rice? \_\_\_\_\_

How many times a week do you eat take-away Food? \_\_\_\_\_

How often do you eat red meat per week? (e.g. beef, lamb, pork) \_\_\_\_\_

How often do you cook at home per week? \_\_\_\_\_

How often do you white meat per week?(e.g. chicken, turkey, fish) \_\_\_\_\_

Where do you usually do your shopping? \_\_\_\_\_

How often do you eat oily fish per week?(e.g. fresh tuna, salmon, sardines,mackerel, kipper) \_\_\_\_\_

Do you tend to eat low-fat food products? \_\_\_\_\_

Do you use margarine or butter? \_\_\_\_\_

How much cow's milk do you consume on an average day? ( including cows milk cheese) \_\_\_\_\_

What are your favorite foods: \_\_\_\_\_

Do you use skimmed milk or whole milk? \_\_\_\_\_

Soy, Rice, Almond or Hemp Milk? \_\_\_\_\_

Do you crave any particular foods? \_\_\_\_\_

How often do you eat chocolate or sweets per week? \_\_\_\_\_

Are there any foods or drink that cause your symptoms to worsen? \_\_\_\_\_

How often do you eat snack foods per week? (e.g. chips, salted nuts etc) \_\_\_\_\_

What is your preferred alcoholic drink? \_\_\_\_\_

How many caffeinated teas, coffees, energy drinks and/or colas do you drink daily? \_\_\_\_\_

How many glasses of alcohol do you consume on average during the week? \_\_\_\_\_

Do you add sugar to your tea/coffee Y/N \_\_\_\_\_

(If so, please state how many teaspoons) \_\_\_\_\_

How many glasses of alcohol do you consume on average during the weekend? \_\_\_\_\_

Do you drink more than 1 litre of water per day? \_\_\_\_\_

What kind of music do you listen to? \_\_\_\_\_

What are your favorite colors? \_\_\_\_\_

What colors do you tend to wear often? \_\_\_\_\_

What are your favorite fabrics for clothing? \_\_\_\_\_

Is there any other information you feel is relevant which has not been asked anywhere else in the Questionnaire/ \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Feel free to add any relevant information on a separate piece of paper.