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Health & Symptom Questionnaires

The health information you provide will be used to assist your registered dietitian/nutritionist in understanding your overall health condition, to customize and plan the implementation of your food sensitivity results, and as a baseline to monitor your progress.

Please complete this information prior to your appointment. Please print/write clearly using black ink.

Doctor/Healthcare Provider Name:

Patient First Name:

Last Name:

Street Address:

City:

State

Zip code

E-mail Address:

Preferred Contact Phone:

Best hours to call:

Alternate Phone 1:

Best hours to call:

Alternate Phone 2:

Best hours to call:

Health & Symptom Questionnaires

What you eat and how you eat can either strengthen your body, helping you live a healthier happier life, or it can give rise to unwanted symptoms, illness, and a decreased quality of life.

Migraines, headaches, irritable bowel syndrome, chronic gastrointestinal problems, and many other symptoms can often be caused by adverse reactions to foods and additives in your diet. Many times these reactions are delayed or hidden, which can make them very difficult to identify.

Food sensitivity testing, along with your history, quickly uncovers the foods and additives responsible for symptoms and provides a strong foundation on which to build a diet that you tolerate so that you can overcome diet-related health problems.

Step-By-Step Instructions:

1. Follow the instructions for each of the following questionnaires and surveys. Please provide complete and accurate information. The information you provide will be used to customize your plan to meet your needs.
2. If you have additional pertinent test or office visit reports that could be helpful, then please provide this information.
3. E-mail, fax, or bring the completed forms to your dietitian as requested.
4. E-mail: Lea@NutritionHealthServices.com
5. FAX: (727) 822 - 6616.
6. Do not hesitate to contact us if you have any questions prior to your appointment.
7. You may want to visit: www.alcat.com as a resource to learn more about the Food Sensitivity Testing.

Symptom Survey

Date:	Patient Name:	Patient Signature:
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Please rate the intensity and frequency of your symptoms using the SCALE OF SYMPTOM POINTS listed below. Score every symptom based on your average experience **weekly over the last month**. Just copy a darkened circle and paste onto your selection, fill in the circle, or place an "x" on the circle.

SCALE OF SYMPTOM POINTS

Grand Total:

IF you did not suffer from the symptom ever or almost never, leave it blank.

- = 1 = Was **MILD** and **OCCASIONAL** (less than 2 times per week)
- = 2 = Was **MILD** and **FREQUENT** (2 or more times per week)
- = 3 = Was **SEVERE** and **OCCASIONAL** (less than 2 times per week)
- = 4 = Was **SEVERE** and **FREQUENT** (2 or more times per week)

<p>CONSTITUTIONAL</p> <p>○○○○ Fatigue (sluggish, tired)</p> <p>○○○○ Hyperactive (nervous energy)</p> <p>○○○○ Restless (can't relax/sit still)</p> <p>○○○○ Sleepiness During Day</p> <p>○○○○ Insomnia at Night</p> <p>○○○○ Malaise (Feel Lousy)</p> <p>_____ TOTAL (0-24)</p> <p>EMOTIONAL/MENTAL</p> <p>○○○○ Depression</p> <p>○○○○ Anxiety</p> <p>○○○○ Mood Swings</p> <p>○○○○ Irritability</p> <p>○○○○ Forgetfulness</p> <p>○○○○ Lack of concentration/focus</p> <p>_____ TOTAL (0-24)</p> <p>HEAD/EARS</p> <p>○○○○ Migraine (diagnosed)</p> <p>○○○○ Headache (any kind)</p> <p>○○○○ Earache</p> <p>○○○○ Ear Infection</p> <p>○○○○ Ringing in Ear</p> <p>○○○○ Itchy Ears</p> <p>○○○○ Discharge From Ears</p> <p>_____ TOTAL (0-28)</p> <p>SKIN</p> <p>○○○○ Blemishes, Acne</p> <p>○○○○ Rashes, Hives</p> <p>○○○○ Eczema</p> <p>○○○○ "Rosy" Cheeks</p> <p>_____ TOTAL (0-16)</p>	<p>NASAL/SINUS</p> <p>○○○○ Post Nasal Drip</p> <p>○○○○ Sinus Pain</p> <p>○○○○ Runny Nose</p> <p>○○○○ Stuffy Nose</p> <p>○○○○ Sneezing</p> <p>_____ TOTAL (0-20)</p> <p>MOUTH/THROAT</p> <p>○○○○ Sore Throat</p> <p>○○○○ Swollen Throat</p> <p>○○○○ Swelling of Lips/Tongue</p> <p>○○○○ Gagging/Throat Clearing</p> <p>○○○○ Canker Sores</p> <p>_____ TOTAL (0-20)</p> <p>LUNGS</p> <p>○○○○ Wheezing</p> <p>○○○○ Chest Congestion</p> <p>○○○○ Dry Cough</p> <p>○○○○ Wet Cough</p> <p>_____ TOTAL (0-16)</p> <p>EYES</p> <p>○○○○ Red or Swollen Eyes</p> <p>○○○○ Watery Eyes</p> <p>○○○○ Itchy Eyes</p> <p>○○○○ Dark Circles" or "Bags"</p> <p>_____ TOTAL (0-16)</p> <p>GENITOURINARY</p> <p>○○○○ Increased Urinary Frequency</p> <p>○○○○ Painful Urination</p> <p>_____ TOTAL (0-8)</p>	<p>MUSCULOSKELETAL</p> <p>○○○○ Joint Pains/Aching</p> <p>○○○○ Stiff Joints</p> <p>○○○○ Muscle Aches</p> <p>○○○○ Stiff Muscles</p> <p>_____ TOTAL (0-16)</p> <p>CARDIOVASCULAR</p> <p>○○○○ Irregular Heartbeat</p> <p>○○○○ High Blood Pressure</p> <p>_____ TOTAL (0-8)</p> <p>DIGESTIVE</p> <p>○○○○ Heartburn/Reflux</p> <p>○○○○ Stomach Pains/Cramps</p> <p>○○○○ Intestinal Pains/Cramps</p> <p>○○○○ Constipation</p> <p>○○○○ Diarrhea</p> <p>○○○○ Bloating Sensation</p> <p>○○○○ Gas (of Any Kind)</p> <p>○○○○ Nausea, Vomiting</p> <p>○○○○ Painful Elimination</p> <p>_____ TOTAL (0-36)</p> <p>WEIGHT MANAGEMENT</p> <p>_____ Record Actual Weight</p> <p>_____ Height</p> <p>○○○○ Fluctuating Weight</p> <p>○○○○ Food Cravings</p> <p>○○○○ Water Retention</p> <p>○○○○ Binge Eating or Drinking</p> <p>○○○○ Purging (all methods)</p> <p>_____ TOTAL (0-20)</p>
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Other symptoms or comments:

Allergy History

Does anyone in your family have allergies? Yes No

If Yes: Parent Sibling Other Blood Relative:

If Yes, what are they allergic to? Food Medication Pollen Dust Other:

Do you have any known allergies? Yes No

List all foods, additives, and medications that you KNOW OR SUSPECT cause symptoms in any part of your body:

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Vitamins & Herbs Taken On A Regular Basis

Diet History

of times you typically skip Breakfast each week:

How many snacks do you typically eat per day?

of times you typically skip Lunch each week:

Circle below all snacks you typically eat

of times you typically skip Dinner each week:

Chips	Cookies	Candy	Fruit	Veggies	Other
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Place a letter next to each beverage indicating how often you consume it using the following scale:
D = Daily, W = Weekly, M = Monthly 0 = Never or almost never.

___ Water ___ Coffee ___ Tea ___ Soda ___ Milk ___ Juice ___ Wine ___ Beer ___ Other:

How many times do you typically eat out each week?

How many times per week do you eat at a "Fast Food" restaurant?

What foods (if any) do you crave?

Are there any foods you could not give up for 2 weeks? If yes, list:

What have you tried so far to resolve your health problems?

On a scale from 1-10, how committed are you to getting better?

Health Goals

The positive benefits experienced by changing your diet and lifestyle can be tremendous. What health goals do you want to accomplish? Whether your aim is to decrease the frequency or severity of specific symptoms, or to increase energy and general wellness, your dietitian will work with you to design a plan that will help you achieve those goals. The first step is to write down your goals and then discuss them with your dietitian to develop your personalized plan.

1.	4.
2.	5.
3.	6.

Patient Name:

Date:

INSTRUCTIONS: This survey asks for views about your health. This information will help keep track of how you feel and how well you are able to do your usual daily activities. Answer every question marking the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

1. In general, would you say your health is:
(Circle One)

1. Excellent
2. Very Good
3. Good
4. Fair
5. Poor

2. Compared to one year ago, how would you rate your health in general at this time?
(Circle One)

1. Much better now than one year ago
2. Somewhat better now than one year ago
3. About the same as one year ago
4. Somewhat worse than one year ago
5. Much worse now than one year ago

3. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?
(Circle the appropriate number for each question)

Activities	Yes, limited a lot	Yes, limited a little	No, not limited
a. Vigorous activities, such as running, lifting heavy objects, or participation in strenuous sports	1	2	3
b. Moderate activities, such as moving a table, Vacuuming, bowling or golfing	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling, or stooping	1	2	3
g. Walking more than a mile	1	2	3
h. Walking several blocks	1	2	3
i. Walking one block	1	2	3
j. Bathing or dressing yourself	1	2	3

4. During the past 4 weeks, have you had any of the following problems with your work or other regular activities as a result of your physical health? (Circle the appropriate number for each question)

a. Cut down on the amount of time you spent on work or other activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Were limited in the kind of work or other activities	Yes = 1	No = 2
d. Had difficulty performing the work or other activities (For example – requiring an extra effort)	Yes = 1	No = 2

5. During the past four weeks, have you had any of the following problems with your work or other regular daily activities as result of any emotional problems (such as feeling depressed or anxious)? (Circle the appropriate number for each question)

a. Cut down on the amount of time you spent on work or other activities	Yes = 1	No = 2
b. Accomplished less than you would like	Yes = 1	No = 2
c. Didn't do work or other activities as carefully as usual	Yes = 1	No = 2

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups? (Circle one)

1. Not at all
2. Slightly
3. Moderately
4. Quite a bit
5. Extremely

7. How much bodily pain have you had during the past 4 weeks? (Circle one)

1. None
2. Very mild
3. Mild
4. Moderate
5. Severe
6. Very severe

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (Circle one)

1. Not at all
2. Slightly
3. Moderately
4. Quite a bit
5. Extremely

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks:
(Circle one number on each line)

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of pep?	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives etc.)?(Circle one)

1. All of the time
2. Most of the time
3. Some of the time
4. A little of the time
5. None of the time

11. How TRUE or FALSE is each of the following statements to you? (Circle one for each line).

	Definitely True	Mostly True	Don't Know	Mostly False	Definitely False
a. I seem to get sick easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5