NUTRITIONAL RE-ASSESSMENT QUESTIONAIRE:

NAME/ACCOUNT:_____________________________________ DATE:___________________

Please score the following conditions using a 0-10 scale where 0 is the worst it has ever been and 10 is the best it has ever been:

OVERALL HEALTH_______ DIET ______ SLEEP ______

EXERCISE ______ WATER INTAKE ______ PAIN ______

STRESS ______

Circle any conditions/goals you believe we have *NOT* helped you to control/achieve (based on what was reviewed in your previous appointment):

allergies fatigue gallbladder problem weight loss/weight gain thyroid problems

cancer diabetes sleep issues anxiety/depression ADD/ADHD

rash/Rosacea eczema/dermatitis/psoriasis/dry skin acne rheumatoid arthritis (RA)

joint pain (i.e. knee, wrist) _________________________ fibromyalgia gout

high blood pressure high cholesterol congestive heart failure seizures

loss of smell/loss of taste foggy brain/poor concentration headaches/migraines

dizziness constipation/irregular bowel habits diarrhea IBS Crohn’s Celiac’s

heartburn/acid reflux abdominal pain Leaky Gut gas/bloating chronic cough

shortness of breath menstrual issues/inconsistencies hormonal imbalances

Any other health concern not listed:

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Briefly list why your expectations were not met:

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Are there any new health concerns since your last consultation or assessment:

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