PATIENT NAME_____

DATE _____

NUTRITIONAL EVALUATION QUESTIONAIRE

PLEASE CIRCLE ALL THAT APPLY

DEPRESSION

FATIGUE

POOR MEMORY

FEELING "SPACY", BRAIN FOG

SINUSITIS

ABDOMINAL PAIN, BLOATING

VAGINAL DISCHARGE, ITCHING

OBESITY, INABILITY TO LOSE WEIGHT

IRRITABILITY, MOODINESS

CHRONIC RASHES, ITCHING

HYPOTHYROIDISM

FOOD SENSITIVITIES

HYPOADRENIA

INSOMNIA

HEADACHES

HYPOGLYCEMIA

PROSTATITIS

PMS

DIARRHEA

CONSTIPATION

CHRONIC SUBLAXATIONS

CHEMICAL SENSITIVITIES