

## Better Gut Better Health Adult Intake Questionnaire

My ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to these questions. Health issues are usually influenced by several factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with your health challenges. **To enhance your scheduled consult time, please have this back to me at least 1 day prior to your appointment, if possible. You can scan and email to [bettergutbetterhealth@gmail.com](mailto:bettergutbetterhealth@gmail.com) or fax to 603-868-1077**

Name _____		Today's date _____	
Address: _____		City: _____	State: _____ Zip: _____
E-mail Address: _____		Fax Number: (_____) _____ - _____	
Home Phone:(_____) _____ - _____		Work:(_____) _____ - _____ Cell:(_____) _____ - _____	
Birthdate ____/____/____ month day year	Age: _____	Place of Birth : _____ city/town (and country if not in US)	
Occupation: _____		Referred by: _____	
Height: _____ ' _____ "	Weight: _____	Sex: ____	Desired Weight: _____ Last Age at Desired Weight: _____
Highest Adult Weight: _____ What Age?: _____		Lowest Adult Weight: _____ What Age?: _____	
Have you ever dieted?: <i>r</i> Yes <i>r</i> No      If Yes, how many times in your adult life? _____			
Which diet(s) worked: _____			

1. Please check appropriate box:

African American       Hispanic       Mediterranean       Asian  
 Native American       Caucasian       Northern European       Other \_\_\_\_\_

2. Please **rank** current/ongoing problems **by priority** and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
<b>Example:</b> Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			

### 3. PAST MEDICAL AND SURGICAL HISTORY:

3. ILLNESSES	WHEN	COMMENTS
a. Anemia (type)		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel		
s. Kidney stones		
t. Mononucleosis		
u. Pneumonia		
v. Sinusitis		
w. Sleep Apnea		
x. Stroke		
y. Thyroid disease		
z. Other (describe)		
<b>INJURIES</b>		
ab. Back injury		
ac. Broken Bones		
ad. Head Injury		
ae. Neck Injury		
af. Other (acute) ex: sprained muscle		
ag. Other (chronic) ex: bad knees		
<b>DIAGNOSTIC STUDIES</b>		
ai. Bone Scan		
aj. CAT Scan		
ak. EKG		
al. MRI		
am. Upper/Lower GI Series		
an. Other (describe)		
<b>OPERATIONS</b>		
ao. Dental Surgery		
ap. Gallbladder		
aq. Hysterectomy		
ar. Tonsillectomy		
as. Other (describe)		

4. Please indicate significant family medical history (ex: cancer, diabetes, heart disease, etc.)

Maternal side: \_\_\_\_\_

Paternal side: \_\_\_\_\_

5. Are your parents living?  No  Yes

If no, comment: \_\_\_\_\_

6. Did you have any health issues as a child?  No  Yes - What age? \_\_\_\_\_

Describe: \_\_\_\_\_

7. As a **child**, where there foods you avoided?  No  Yes-(please specify below)

Food	Symptoms
Ex: Milk	Ex: Gas and diarrhea

8. Please mark in the chart below with information about recent bowel movements:

Frequency:	Color:
More than 3 times a day	Dark brown
2-3 times a day	Medium brown
One time per day	Very dark or black
4-6 times a week	Greenish
2-3 times a week	Blood is visible
Once or fewer a week	Varies a lot
<b>Consistency:</b>	Yellow, light brown
Soft and well formed	Greasy, shiny appearance
Often float	
Difficult to pass	
Diarrhea	
Thin, long or narrow	
Small and hard	
Loose, but not watery	
Alternating between hard and loose/watery	

9. Do you experience intestinal gas? (check all that apply)

present with pain  foul smell  little odor  excessive daily  occasionally

10. Do you experience anal itching?  frequently  occasionally  rarely  never

11. Do you experience any heartburn, chest pressure, or stomach pain?  No  Yes

If yes, do you take anything for relief (list):

\_\_\_\_\_

\_\_\_\_\_

**WOMEN ONLY: (Questions 12-21)**

12. Have you ever been pregnant?  No  Yes

If yes, please answer the following:

a. Number of miscarriages: \_\_\_\_\_ b. Number of abortions: \_\_\_\_\_ c. Number of preemies: \_\_\_\_\_

d. Number of term births: \_\_\_\_\_ e. Birth weight of largest baby: \_\_\_\_\_ Smallest baby: \_\_\_\_\_

f. Did you develop toxemia?  No  Yes

g. Have you had any other problems with pregnancy?  No  Yes

If yes, describe: \_\_\_\_\_

13. Age of first mensus: \_\_\_\_\_

14. Date of last Pap Smear: \_\_\_\_\_ Normal  Abnormal

15. Date of last Mammogram: \_\_\_\_\_ Normal  Abnormal

16. Do you currently use contraception?  No  Yes-(type) \_\_\_\_\_

17. Are you currently taking birth control pills?  No  Yes-(how long? \_\_\_\_\_)

If you're on the pill please comment on physical or mental changes from before taking to now:

\_\_\_\_\_

\_\_\_\_\_

18. Do you currently experience PMS (i.e. water retention, breast tenderness, irritability, etc.)?

No  Yes-(specify) \_\_\_\_\_

19. Have you every experienced PMS in the past?  No  Yes – When?: \_\_\_\_\_

20. Are you still menstruating?  Yes  No - (age of last period: \_\_\_\_\_)

21. Are you experiencing menopause symptoms?  No  Yes

22. Do you take:  Estrogen  Estrace  Premarin  Other-(specify) \_\_\_\_\_

23. **(Men and Women)** Do you have urinary problems?  No  Yes

If yes, please specify:  Nightly urination  Frequent day time urination  Hesitancy

Irregular  Dribbling afterwards  Frequent urge to urinate  Difficulty

Feeling of incomplete emptying  Burning sensation

24. **(Men Only):** Do you have prostate swelling?  No  Yes

**DENTAL, etc.:**

25. Do you have amalgam (silver, black or grey) fillings?  No  Yes (how many? \_\_\_\_\_)

26. Have you every had fillings replaced?

No  Yes-(how many? \_\_\_\_\_ when? \_\_\_\_\_ with what material? \_\_\_\_\_)

27. Do you have root canals?  No  Yes (how many? \_\_\_\_\_) Any Problems? \_\_\_\_\_

28. Have you had any cavities in the last 2 years?  No  Yes (how many? \_\_\_\_\_)

29. Do your gums ever bleed?  No  Yes-(how often? \_\_\_\_\_)

30. Do you ever grind your teeth?  No  Yes

31. Do you have any artificial joints or implants anywhere in the body or mouth?  No  Yes

**SOCIAL:**

32. How well have things been going for you lately?:

	Great	Good	Could be better	Not very good	Does Not Apply
a. school					
b. job					
c. social life					
d. close friends					
e. sex					
f. your attitude					
g. boy/girlfriend					
h. children					
i. parents					
j. spouse					

33. With whom do you live? List age of children, if any.

\_\_\_\_\_

34. What is the attitude of those close to you concerning your health?

Supportive  Not supportive  Indifferent

35. Are you currently married, or have you ever been married?  No  Yes

If yes, when \_\_\_\_\_ If yes, spouse's occupation: \_\_\_\_\_

Have you been separated or divorced?  No  Yes - If yes, when? \_\_\_\_\_

36. What are your hobbies and leisure activities? \_\_\_\_\_

37. Describe previous jobs/work: \_\_\_\_\_

38. Have you lived outside of the United States?  No  Yes If yes, where/when? \_\_\_\_\_

39. What is your total amount of airline trips, in the last year? \_\_\_\_\_

Estimated total in life: \_\_\_\_\_ How many out of the country: \_\_\_\_\_

40. Have **you** experienced any major losses in your life?  No  Yes

If so, please comment: \_\_\_\_\_

41. Have you or your **family** recently experienced any major life changes (such as a job change)?  No  Yes

If yes, please comment: \_\_\_\_\_

42. Have you ever had psychotherapy or counseling?  No  Yes

If yes, what kind? \_\_\_\_\_ when? \_\_\_\_\_

Additional comments: \_\_\_\_\_

\_\_\_\_\_

**LIFESTYLE:**

43. How important is religion (or spirituality) to you?  
 Not at all important     Somewhat important     Extremely important

44. Do you meditate?  occasionally     often     never

45. How much control do you feel you have over your current state of health? Rate 1-10 (none-all) \_\_\_\_\_  
Comment: \_\_\_\_\_  
\_\_\_\_\_

46. How much time have you lost from work or school in the past year due to illness?  
 0-2 days     3-5 days     6-14 days     more

47. What is your usual bed time? \_\_\_\_\_ wake time? \_\_\_\_\_

48. How well do you sleep? (check all that apply)  
 Adequate-(sleep through the night)     Wake up feeling well rested  
 Trouble falling asleep     Wake up still tired  
 Trouble staying asleep-(How many times do you wake during the night? \_\_\_\_\_)

49. Check off typical bedtime activities:  
 Watch television     Read a book     Listen to music     Bed time snack  
 Meditate     Bathe/shower     Drink alcohol     Drink caffeinated beverage  
 Other-(specify) \_\_\_\_\_

50. Do you ever need to take a sleep aid?  No     Yes – Which ones at what dose?  
\_\_\_\_\_

How often \_\_\_\_\_

51. Do you exercise regularly now?  No     Yes-(specify):    Have you in the past?  No     Yes  
 Once per week     2 times per week     3 times per week     4 times per week or more  
Amount per session:  less than 15 minutes     15-30 minutes     30-45 minutes     > 45 minutes  
 Other-(specify) \_\_\_\_\_

52. What type of exercises do you do currently (dog walking does not count)?  
 Jogging     Walking     Weight training     Water sports     Aerobics     Yoga  
 Other-(specify) \_\_\_\_\_

53. Do you get sun exposure?  No     Yes-(specify)     Daily     Weekly    How much? \_\_\_\_\_

54. Do you wear sun block?  No     Yes-(percentage of time \_\_\_\_\_)

**ALLERGY & TOXIC POTENTIAL:**

55. Do you have any pets or farm animals?  No     Yes - List: \_\_\_\_\_  
If yes, where do they live?  Indoors     Outdoors     Both

56. Do odors such as perfume, cleaning solutions, smoke, etc. affect you?  No     Yes  
If yes, explain: \_\_\_\_\_  
\_\_\_\_\_

57. Have you, to your knowledge, been exposed to toxic metals at your job or at home?  
 \_\_No \_\_Yes: \_\_Lead \_\_Cadmium \_\_Arsenic \_\_Mercury \_\_Aluminum  
 Explain: \_\_\_\_\_
58. To your knowledge, have you ever been exposed to an ongoing amount of any of the following?  
 \_\_No \_\_Solvents \_\_Paints \_\_Pesticides \_\_Petrochemicals  
 \_\_Coal \_\_Hydrocarbons \_\_Mold \_\_Other (specify): \_\_\_\_\_
59. Do you now or have you recently lived in an older home (pre 1970's)?: \_\_No \_\_Yes  
 If yes, how old is/was home: \_\_\_\_\_ How long have/did you live there? \_\_\_\_\_
60. Have you ever lived or worked in a water damaged building? \_\_No \_\_Yes  
 If yes, when? \_\_\_\_\_ How long? \_\_\_\_\_
61. Have past activities/hobbies exposed you to photography chemicals, paints, glues, or dyes?  
 \_\_No \_\_Yes-(explain) \_\_\_\_\_  
 How often do you wear dry cleaned clothing? \_\_\_\_\_
62. Do you have a regular lawn care service? \_\_No \_\_Yes-(how often? \_\_\_\_\_)
63. Do you regularly spray for pests outdoors? \_\_No \_\_Yes-(how often? \_\_\_\_\_)
64. Do you use bug spray (outside) or insecticides (indoors) on a regular basis? \_\_No \_\_Yes
65. How often are you exposed to burning coal, bonfires, fire pits, etc.? \_\_\_\_\_
66. Do you consume alcohol regularly now or did you consume alcohol regularly in the past?  
 \_\_No \_\_Yes- Currently: \_\_1-3 drinks per week \_\_4-6 \_\_7-10 \_\_10 or more  
 \_\_Yes- In the past: \_\_1-3 drinks per week \_\_4-6 \_\_7-10 \_\_10 or more  
 If you have quit, when? \_\_\_\_\_
67. Have you ever used tobacco? \_\_No \_\_Yes-(specify: \_\_\_\_\_) If  
 yes, number of years: \_\_\_\_\_ Amount per day: \_\_\_\_\_ Year quit? \_\_\_\_\_
68. Are you now or were you ever regularly exposed to second hand smoke? \_\_No \_\_Yes When? \_\_\_\_\_
69. Have you ever used recreational drugs? \_\_No \_\_Yes-(specify: \_\_\_\_\_)

**MEDICATIONS:**

70. What medications are you taking now? Please also include non-prescription drugs you take **daily/regularly**.

Medication Name	Purpose	Dosage	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

71. Do you take any other over the counter medications on an **occasional basis**?  
 If yes, which one(s)? \_\_\_\_\_  
 \_\_\_\_\_

72. How many times have you taken antibiotics as an infant or child?  
 Less than 5 times     More than 5 times     More than 10 time     So many times I lost count  
 Reason: \_\_\_\_\_  
 \_\_\_\_\_

73. As an adult, how often do you take antibiotics?  
 Never     Once a year (on average)     1-3 times a year (on average)  
 Longer-(explain) \_\_\_\_\_  
 Why? \_\_\_\_\_

74. Were you ever on antibiotics for a prolonged period of time?     No     Yes  
 If yes, explain: \_\_\_\_\_  
 \_\_\_\_\_

75. Fill in the chart below for how many times have you taken oral steroids (e.g. Cortisone, Prednisone, etc.)?

	Less than 5 times	Greater than 5 times	Greater than 10 times
Infancy/Childhood			
Teen			
Adulthood			

76. List all vitamins, minerals, and other nutritional supplements that you are currently taking.  
 Indicate unit (mg or IU), and form (for example: calcium carbonate vs. calcium lactate).

Vitamin/Herbal Supplement(s)	Brand	How Many and When?	Start Date
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

**\*\*If your being seen in person, please bring bottles with you to your appointment\*\***



**DIETARY HABITS:**

77. Are you currently on a special diet (i.e., vegetarian, South Beach, etc)?  No  Yes  
 If yes, how long and describe: \_\_\_\_\_  
 \_\_\_\_\_

78. Usual Breakfast time: \_\_\_\_\_ Lunch time: \_\_\_\_\_ Dinner time: \_\_\_\_\_  
 Snack time: \_\_\_\_\_ Snack time: \_\_\_\_\_ Snack time: \_\_\_\_\_

79. Place a mark next to the food/drink that applies to a typical day of your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner	Usual Snacks
None	None	None	None
Cereal	Eat in cafeteria	Pasta	Nuts
Wheat Bran	Eat in restaurant	Potato	Fruit
Oatmeal	Leftovers	Brown rice	Vegetables
Toast	Meat sandwich	White rice	Pretzels
Bagel	Fish sandwich	Beans (legumes)	Potato Chips
Sweet roll	Lettuce (on sandwich)	Fish	Corn Chips
Donut	Tomato	Red Meat	Crackers
Eggs	Salad	Poultry	Cheese
Bacon/Sausage	Salad dressing	Salad	Cookies
Fruit	Soup	Salad dressing	Cake/Pastries
Yogurt	Fruit	Green vegetables	Nut butters
Milk	Yogurt	Carrots	Cereal
Juice	Milk	Yellow vegetables	Ice cream
Tea	Juice	Milk	Trail mix
Coffee	Tea	Juice	Dried fruit
Water	Coffee	Tea	Other: (list)
Butter	Water	Coffee	
Margarine	Regular soda	Water	
Sugar	Diet soda	Regular soda	
Sweetener	Butter	Diet soda	
Leftovers	Margarine	Butter	
Other:	Mayonnaise	Margarine	
	Sugar	Sugar	
	Sweetener	Sweetener	
	Other:	Other:	

80. Do you currently or typically have any symptoms **immediately after** eating? (For example: belching, fatigue, bloating, sneezing, hives, etc.?  No  Yes If yes, are these symptoms associated with any particular food that you are aware of? Explain:(example: Milk-gas cause diarrhea) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

81. Do you feel you have **delayed symptoms** after eating certain foods, such as: fatigue, muscle aches, sinus congestion, etc.? *Delayed symptoms may not be evident for 24 hours or more after eating.*  
 No  Yes  
 If yes, specify: \_\_\_\_\_  
 \_\_\_\_\_

82. How much of the following do you consume on average?

Food	Amount Per Day	Amount Per Week
Candy		
Cheese		
Chocolate		
Cups of caffeinated coffee		
Cups of decaffeinated coffee		
Cups of hot chocolate		
Cups of tea (containing caffeine)		
Diet sodas (cans)		
Regular soda (cans)		
Ice cream		
Salty snacks		
Slices white bread/rolls/1/2 bagel		
Nuts		

83. Do you feel **much worse** when you eat any of the following: (check all that apply)

- high fat foods   
  refined sugar (junk foods)   
  high protein foods   
  fried foods  
 high carbohydrate foods   
  1 or 2 alcoholic drinks  
 (breads, pastas, potatoes)   
  Other (specify): \_\_\_\_\_

84. Do you feel **much better** when you eat a lot of: (check all that apply)

- high fat foods   
  refined sugar (junk foods)   
  high protein foods   
  fried foods  
 high carbohydrate foods   
  1 or 2 alcoholic drinks  
 (breads, pastas, potatoes)   
  Other (specify): \_\_\_\_\_

85. Do you feel **worse** at certain times of the year?     No     Yes-(when? \_\_\_\_\_)  
 How do you feel? \_\_\_\_\_

86. Do you feel **better** at certain times of the year?     No     Yes-(when? \_\_\_\_\_)  
 How do you feel? \_\_\_\_\_

87. Does skipping a meal affect you in any way?     No     Yes – Explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

88. Do you ever crave or “binge” on certain foods?     No     Yes  
 Which foods, how often and comment on possible stressors/triggers? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

89. Do you avoid certain foods for any reason?     No     Yes  
 Which foods and why? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Food Frequency List

Please indicate the **approximate number of times** you have eaten these foods in a typical week. For each section you may **cross out** food/beverages seldom consumed, and **circle** foods/beverages you do eat.

Consumed in the past 7 days	Number of Times	Consumed in the past 7 days	Number of Times
<b>Vegetables: Dark green leafy:</b> spinach, Romaine, leaf lettuce, Caesar Salad, etc.		<b>Fish: (list):</b> fresh, fried or canned?	
<b>Iceberg lettuce</b> or <b>bagged salad combos</b> , celery cucumbers, zucchini		<b>Poultry: Chicken:</b> dark meat, breast <b>Turkey:</b> dark meat, breast, lunch meat, turkey bacon	
<b>Broccoli</b> , Brussels sprouts, cabbage/coleslaw, kale, turnip or mustard greens		<b>Beef:</b> hamburgers, steak meatloaf, stew, chili Is it usually regular, lean, grass fed or organic?	
Fresh/frozen <b>mixed</b> veggies: corn, green beans, peas		<b>Pork:</b> ham, sausage, bacon	
<b>Yellow-orange veg:</b> carrots, squash, sweet potatoes		<b>Hot dogs:</b> beef or turkey, bratwurst, italian sausage, etc.	
<b>Tomatoes</b> , pasta sauce, tomato juice, V-8, salsa, etc		<b>Fried foods:</b> fries, chicken, etc.	
<b>Fresh vegetable juices:</b>		<b>Lunchables®</b> , bologna, salami, etc.	
<b>Other:</b> <span style="float: right;"><b>ORGANIC?</b></span>		<b>Vegetarian foods: (list):</b>	
		<b>Indian Vegetarian foods: (list):</b>	
<b>Fruits:</b> (circle): banana, pear, apple, grapes, kiwi <b>Other:</b>		<b>Beans, legumes, peas:</b> bean/lentil soup, bean burritos, veg chili, split pea soup, etc.	
<b>Berries</b> (list):		Vegetarian foods: (list):	
<b>Canned/jar fruit:</b> applesauce, pears, peaches		<b>Veggie burgers, TVP, tofu, tempeh, seitan, Quorn® products, etc.</b>	
<b>Dried fruits:</b>		<b>Raw nuts/seeds:</b> almonds, sunflower seeds, pecans, walnuts, etc.	
<b>Wheat bread:</b> rolls, buns, sandwiches, pita, bagel White, whole grain, low carb, spelt, Ezekiel®		<b>Trail mix</b> , roasted salted nuts	
<b>Cold cereal (list):</b>		<b>Peanuts</b> , peanut butter, <b>almond</b> butter, tahini, etc	
<b>Hot cereal (list):</b>		<b>Protein powders: soy, whey, egg or rice?</b>	
<b>Pancakes</b> , waffles <span style="float: right;"><b>tortillas:</b> corn or flour</span>		<b>Protein:</b> liquid (ready-to-drink)	
<b>Muffins</b> , donuts, sweet rolls, granola bars		<b>Flax seed meal</b> or flax oil, <b>cod liver oil?</b>	
<b>Pretzels</b> , crackers, etc.		<b>Butter:</b> <span style="float: right;"><b>ORGANIC?</b></span>	
<b>Gluten-free foods:</b>		<b>Margarine: (list brand):</b>	
<b>Rice:</b>		<b>Potato chips</b> , Fritos®, Doritos®, Pringles®, etc.	
<b>Potatoes:</b> mashed, boiled or bakes? Red or white?		<b>Popcorn: prepackaged or homemade?</b>	
<b>Pasta:</b> spaghetti, lasagna, macaroni, pasta salad, etc.		<b>Candy (list):</b>	
		<b>Pie, cake, cookies, other snacks (list):</b>	
<b>Eggs:</b> whole or whites only?		<b>Gum</b> , breath mints: regular or sugarless?	
<b>Dairy:</b> Cow's milk: skim, 2%, or whole? <b>ORGANIC?</b>		<b>Coffee/espresso drink?</b> Regular or decaf? # of 8oz cups?	
<b>Yogurt, cheese</b> , nachos, cottage cheese <b>ORGANIC?</b>		<b>Tea:</b> black, green, white, herbal infusion.	
<b>Pizza:</b> sausage, peperoni, vegetable, etc.		<b>Sugar or no/low calorie sweetener? (list):</b>	
<b>Ice cream, frozen yogurt</b> , shakes, malts, etc.		<b>Soda pop: regular or diet? (list):</b>	
<b>Soy milk, goat milk, rice milk, almond milk</b>		<b>Alcohol</b> beverage: wine, beer, hard liquor	
<b>Circle other frequent foods:</b> Frozen/microwave meals: Weight Watchers®, Lean Cuisine®, Healthy Choice®, Mexican cuisine, Indian cuisine, Chinese/Thai, Vegetarian, Atkins®, Low carb, SlimFast®, etc.			
<b>Average daily water intake in 8 oz glasses (not counting soda pop or coffee):</b> 1-2      3-4      5-6      7-8      9-10			
Is it: <b>tap water, filtered tap water, spring water, distilled, etc.?</b>			

