VERONICA MONTURE
FUNCTIONAL WELLNESS

Holistic Nutrition Intake Questionnaire

Please complete the questionnaire as completely as possible. The more detail that you can provide, the better I can help you!

Name: _____ Date: _____

1. Top 3 health concerns/symptoms in detail:

    1.)

    2.)

    3.)

2. Gender: _____ Age: _____ Height: _____ Weight: _____ Blood Type: _____

3. How many people do you live with? ____ Children & ages: _____
Describe your living arrangements (house/apartment/basement): _____
Do you live city/suburbs/country? _____
Do you have pets? If so, describe: _____

4. Please describe your family's health history

(Food allergies, Asthma, Osteoporosis, Heart disease/disorder, Overweight/Obesity, High Blood Pressure, Cancer, Diabetes, Arthritis, Anemia, Alzheimer's, Blood clotting disorders, Kidney/Bladder disease, Stomach/Duodenal Ulcer, Stroke, Eyesight issues, Hearing issues, Depression, Anxiety, Epilepsy, Other health issues, etc.)

Family Member	Major Health Concerns	Age	Cause of death if deceased
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings:			

5. Personal health history

Allergies?: _____

How often do you get sick? What? Duration?:

_____

_____

Vaccines: _____
Illnesses: _____
Traumatic & stressful events: _____
Accidents & injuries: _____
Emotional history (anxiety, depression, disorders, etc.): _____
Are you currently seeing any practitioners?: _____

6. Surgery history
What/When/how long in hospital? _____
_____
_____

7. Physical Assessment (done in person).

8. Teeth and gums
# of silver amalgams: _____ Root canals? _____ Do you have wisdom teeth? _____
Do you suffer from swollen gums? If so describe: _____

9. Bowel health
Do you suffer from bloating, gas, constipation or diarrhea? If so, how often?
_____
_____
# of bowel movements/day: _____
Recent changers over past month or year: _____

10. Females
Menstrual Health
When did you begin menstruating? ___ Do you still menstruate? _____ Are you regular? _____
How long does your period last?: _____
Do/did you suffer from PMS? _____ If so, indicate specific symptoms - Anxiety, Depression, Irritability/Mood swings, Hydration/Water Retention (describe), Cravings (describe), Pain (describe): _____
_____
Fertility History
# of Pregnancies: _____ Miscarriages?: _____
If pregnant in the past, what did you do/how long did you prepare before conceiving (with supplementation, diet, education, etc. if applicable)? Please describe: _____
_____
Births Control Pill usage (when, how long): _____
Hormone Replacement Therapy? If so, describe: _____
Changes within the past year: _____

11. Toxicity
Do you/did you smoke? If yes, how much and for how long?: _____
Have you been/are you exposed to second hand smoke?: _____
Do you drink alcohol? If yes, indicate how much and frequency: _____
Describe recreational drug use: _____
Do you use conventional cleaning products in your home?: Yes __ No __ I don't know __
Do you use phthalate and paraben-free self-care products?: Yes __ No __ I don't know __
Do you use antiperspirant or deodorant with aluminum?: Yes __ No __ I don't know __
Do you eat organic food?: _____
Do you pay attention to your sugar intake? Please describe: _____
_____
Do you use a microwave, if so, how often?: _____

12. Occupation (current or previous if retired): _____
Are/were you exposed to specific toxic chemicals?: _____
If currently working, do you drive to work? If so, how long is your commute?: _____
Do you work in front of a computer?: _____ Do you use wifi at home/work?: _____
Is your occupation stressful? If so indicate why: _____
Activity level while at work (light/moderate/very), describe: _____

13. Time spent per day:
On the computer: _____ When/where?: _____
On the phone: _____ When/where?: _____
In front of the TV: _____ When/where?: _____

14. Sleep
How long do you sleep? _____ When do you go to bed?: _____ Do you nap?: ____
Darkness of room: _____ Do you wake feeling rested? _____
Do you wake up in the night? If so indicate how often and the time(s): _____
_____
Describe your bedtime routine: _____
_____

15. What food(s) could you not live without?: _____
Do you notice any reactions to certain foods? (Hives, rash, upset stomach, gas, diarrhea, fatigue etc.): _____
_____
How many cups of water do you drink per day?: _____
What is the source of your drinking water?: _____
Number of coffees per day?: _____
What type of oil do you cook with?: _____
Do you use butter or margarine?: _____

How often do you eat at restaurants or take-out food?: _____

16. Medications
List current prescription and Over-the-Counter medications: _____
_____
_____
Past medications (within the past 2 years): _____
_____
Any other significant past medication history: _____
_____

17. Please list current nutritional supplements you are taking (please indicate the brand, dose and frequency): _____
_____
_____
_____
_____

18. Please indicate your exercise routine (type/frequency, etc.): _____
_____
_____
Other activities you do for yourself: _____
List recent travel (destination): _____
_____

19. Stress level on a scale of 1 to 10: _____ Describe where your stress comes from: _____
_____
_____
_____

20. Is there anything else not included on this form that you would like me to know?: _____
_____
_____

5 Day Diet Diary

Please record all food and liquid intake along with the times of intake, wake and sleep. Provide the brands/full name of products and a rough estimation of amounts.

Date:					
	Day 1	Day 2	Day 3	Day 4	Day 5
Wake time:					
Times of food/ liquid intake:					
Sleep time:					