

Rockwell Nutrition Questionnaire

www.RockwellNutrition.com Toll Free: (866) 757-4500 FAX back form to: (866) 727-0784
OR Email to: Nutritionist@RockwellNutrition.com

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____ Date: _____

Phone (home/cell): _____ (w): _____

Age: _____ Height: _____ Weight: _____ Cholesterol: _____

Blood Pressure: _____ Physician Contact Info: _____

Reason for consultation and/or goals: _____

How many times do you usually eat per day? _____

Please recall your last **3 full day's meals**, snacks, and drinks (please try to be very specific and complete, and be sure to include all foods- especially the ones you don't want me to know about ☺).

Day 1: _____

Day 2: _____

Day 3: _____

Nutrition Questionnaire

Do you smoke? _____ If so, _____ per day/week/month

Drink alcohol? _____ If so, type _____

How often? _____ per day/week/month.

How often do you drink coffee? _____ per day/week/month

How often do you have soft drinks? _____ per day/week/month

Do you ever overeat? _____ If so, which foods and how often? _____

Do you have any food allergies, restrictions, or sensitivities? _____

Do you get noticeably irritable, lightheaded, or weak if you haven't eaten in a while? _____

Please list any food aversions and/or foods you dislike: _____

How often do you eat at home/cook your own meals? _____ per day/week/month

Do you crave any of the following frequently?

- | | | |
|---|---|---|
| <input type="checkbox"/> Sweets/ Desserts | <input type="checkbox"/> Meat | <input type="checkbox"/> Peanuts |
| <input type="checkbox"/> Chocolate | <input type="checkbox"/> Fish | <input type="checkbox"/> Alcoholic drinks |
| <input type="checkbox"/> Diet Sodas | <input type="checkbox"/> Milk or Cheese | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bread/Pasta | <input type="checkbox"/> Fried Foods | _____ |

Which oils do you use/consume?

- | | | |
|---------------------------------------|--|--|
| <input type="checkbox"/> Butter | <input type="checkbox"/> Sesame Oil | <input type="checkbox"/> Soybean Oil |
| <input type="checkbox"/> Margarine | <input type="checkbox"/> Peanut Oil | <input type="checkbox"/> Canola |
| <input type="checkbox"/> Olive Oil | <input type="checkbox"/> Corn Oil | <input type="checkbox"/> Sun/Safflower |
| <input type="checkbox"/> Coconut Oil | <input type="checkbox"/> Crisco | <input type="checkbox"/> Mayonnaise |
| <input type="checkbox"/> Flaxseed Oil | <input type="checkbox"/> Vegetable Oil | <input type="checkbox"/> Other _____ |

How is your dental health? _____

How often do you have bowel movements? _____ per day/week/month

Urinate? _____ per day

Are your nails weak or brittle? _____

Nutrition Questionnaire

Rank the condition of your skin without lotion:

- Very Dry
- Dry
- Normal
- Oily
- Combination

Rank the condition of your hair

- Very Dry
- Dry
- Normal
- Oily
- Dandruff

Please check off any of the following that pertain to you (recent past or present):

- | | | |
|--|--|---|
| <input type="checkbox"/> Acne/ blemishes | <input type="checkbox"/> Difficulty <i>gaining</i> weight | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Addiction (alcohol, drugs) | <input type="checkbox"/> Emotional problems (instability or sensitivity) | <input type="checkbox"/> Insomnia |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Intestinal problems |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Anxiety or nervousness | <input type="checkbox"/> Gall bladder problems | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Arthritis (Rheumatoid or Osteo) | <input type="checkbox"/> Gout | <input type="checkbox"/> Loose stools |
| <input type="checkbox"/> Bladder infections (Cystitis) | <input type="checkbox"/> Hair loss or poor hair growth | <input type="checkbox"/> Memory loss or confusion |
| <input type="checkbox"/> Bloating, gas, or indigestion | <input type="checkbox"/> Headaches | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Blood Sugar problems | <input type="checkbox"/> Heart disease or problems | <input type="checkbox"/> Nails, poor growth |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Nails, white spots |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Colds or flu (frequent) | <input type="checkbox"/> Herpes type I mouth/face | <input type="checkbox"/> Parasites |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Herpes type II genital | <input type="checkbox"/> Pregnant or nursing mother |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Respiratory problems |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Severe mood swings |
| <input type="checkbox"/> Diabetes I (insulin dependent) | | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Diabetes II (adult onset) | | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diarrhea | | <input type="checkbox"/> Suicidal tendencies |
| <input type="checkbox"/> Difficulty <i>losing</i> weight | | <input type="checkbox"/> Thyroid condition |
| | | <input type="checkbox"/> Ulcer |
| | | <input type="checkbox"/> Yeast infections |
| | | <input type="checkbox"/> Other: _____ |

Women: Please check any that pertain:

- PMS
- Irregular periods
- Painful menstrual cramps
- Birth control pills
- Low or decreased libido
- Menopause
- Painful intercourse
- Hysterectomy
- Fertility concerns

Men: Please check any that pertain:

- Frequent urination
- Difficulty urinating
- Difficulty with erection
- Low or decreased libido
- Prostate Enlargement
- Un-viable sperm/Fertility concerns

Nutrition Questionnaire

Do you exercise? _____ If so, what kind? _____

How often? _____ Since when? _____

Do you take any nutritional supplements or vitamins? _____ If so, which ones? (be specific. Attach sheet if necessary) _____

Which prescription and over the counter medications do you take currently?

Have you ever done a cleansing fast? _____ If so when and/or how often?

Describe your daily energy levels: _____

Please list any disease, illness, or ailments in your immediate family (i.e. mother-breast cancer, father-type II diabetic, grandfather-heart disease).

Please rate the following:

Daily energy level:

- Excellent
- Good
- Fair
- Poor

Energy level after exercise:

- Excellent
- Good
- Fair
- Poor

Daily stress level:

- Very High
- High
- Moderate
- Low
- None

General enjoyment of life:

- Excellent
- Good
- Fair
- Poor

Nutrition Questionnaire

How much sleep do you get on average each night? _____

Any problems sleeping? _____

Please feel free to expand on any concerns you think are important/relevant to your health. _____

**Please check off the Vegetables, Fruits, & Proteins
you WILL NOT or CANNOT eat**

Vegetable List

<input type="checkbox"/>	Alfalfa Sprouts
<input type="checkbox"/>	Artichoke
<input type="checkbox"/>	Arugula
<input type="checkbox"/>	Asparagus
<input type="checkbox"/>	Beans (black, lima, etc.)
<input type="checkbox"/>	Beets
<input type="checkbox"/>	Black eyed peas
<input type="checkbox"/>	Broccoli
<input type="checkbox"/>	Brussels sprouts
<input type="checkbox"/>	Cabbage
<input type="checkbox"/>	Carrots
<input type="checkbox"/>	Cauliflower
<input type="checkbox"/>	Celery
<input type="checkbox"/>	Chard
<input type="checkbox"/>	Chives
<input type="checkbox"/>	Collard greens
<input type="checkbox"/>	Corn
<input type="checkbox"/>	Cucumber
<input type="checkbox"/>	Eggplant
<input type="checkbox"/>	Endive
<input type="checkbox"/>	Fennel
<input type="checkbox"/>	Garlic
<input type="checkbox"/>	Ginger
<input type="checkbox"/>	Green beans
<input type="checkbox"/>	Kale
<input type="checkbox"/>	Kelp

<input type="checkbox"/>	Leeks
<input type="checkbox"/>	Lentils
<input type="checkbox"/>	Lettuce (romaine, baby greens, etc.)
<input type="checkbox"/>	Mushrooms
<input type="checkbox"/>	Mustard greens
<input type="checkbox"/>	Okra
<input type="checkbox"/>	Onions
<input type="checkbox"/>	Parsley
<input type="checkbox"/>	Parsnips
<input type="checkbox"/>	Peas
<input type="checkbox"/>	Peppers (red or green)
<input type="checkbox"/>	Potato
<input type="checkbox"/>	Pumpkin
<input type="checkbox"/>	Radicchio
<input type="checkbox"/>	Radishes
<input type="checkbox"/>	Rhubarb
<input type="checkbox"/>	Rutabaga
<input type="checkbox"/>	Spinach
<input type="checkbox"/>	Squash
<input type="checkbox"/>	Sweet Potato
<input type="checkbox"/>	Tomato
<input type="checkbox"/>	Turnips
<input type="checkbox"/>	Water chestnuts
<input type="checkbox"/>	Yams
<input type="checkbox"/>	Zucchini

Fruit List

	Apple
	Apricots
	Avocado
	Banana
	Blackberries
	Blueberries
	Boysenberries
	Cantaloupe
	Cherries
	Crabapples
	Cranberries
	Dates
	Figs

	Grapefruit
	Grapes
	Guava
	Honeydew
	Kiwi
	Lemon
	Lime
	Mandarin
	Mango
	Nectarine
	Orange
	Papaya
	Passionfruit

	Peach
	Pear
	Persimmon
	Pineapple
	Plum
	Pomegranate
	Prunes
	Raisins
	Raspberries
	Strawberries
	Tangerine
	Watermelon

Proteins

Meats:

	Chicken
	Ham
	Beef
	Pork

Dairy

	Eggs
	Cheese
	Yogurt
	Cottage Cheese
	Whey Protein Powder

Fish & Seafood:

	Salmon
	Tuna
	Cod
	Grouper
	Sea Bass
	Snapper
	Herring
	Mackerel
	Crab
	Lobster
	Shrimp
	Mussels
	Oysters

Nuts:

	Almonds
	Walnuts
	Brazilnuts
	Cashews
	Hazelnuts
	Macadamia Nuts
	Pecans
	Pistachio
	Almond Butter
	Cashew Butter
	Sesame Butter
	Natural Peanut Butter