Back to Health Wellness Center- Jacob Bastomski D.C..D.I.B.C.N. 1625 State Street (805) 569-5000

Brief Nutritional Questionnaire

On a scale of 0 – 10, with 0 being no problem at all and 10 being a very severe problem, please rate the following: (circle the items which are applicable.)

Minimal Problem Medium Problem Severe Problem

STRESS There is lots of stress in my life which affects me

0 1 2 3 4 5 6 7 8 9 10

MOOD Depression, Anxiety, Irritability

0 1 2 3 4 5 6 7 8 9 10

FATIGUE Lack of energy, Afternoon fatigue

0 1 2 3 4 5 6 7 8 9 10

DIGESTION Bloating, Heartburn, Abdominal pain, Constipation, Diarrhea

0 1 2 3 4 5 6 7 8 9 10

SLEEP Difficult to fall asleep and/or difficult to sleep through the night.

0 1 2 3 4 5 6 7 8 9 10

I sleep a total of ____ hours per night. I wake up approximately ___ times per night.

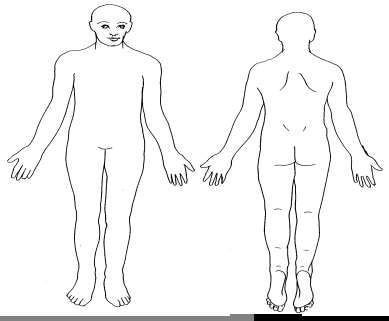
I wake up feeling tired and not ready to start the day.

0 1 2 3 4 5 6 7 8 9 10

PAIN Overall my pain level is

0 1 2 3 4 5 6 7 8 9 10

Please mark pain area(s)



BLOOD SUGAR

I crave sweets

0 1 2 3 4 5 6 7 8 9 10

I crave sweets after a meal

0 1 2 3 4 5 6 7 8 9 10

I get sleepy after a meal

0 1 2 3 4 5 6 7 8 9 10

I get irritable, anxious, dizzy, if I go too long without eating

0 1 2 3 4 5 6 7 8 9 10

Patient Name: _____ Today's Date:_____