Bruce Bonner, MASc. R.N.C.P
Nutritional Assessment Form

Name: _____ Date: _____

Address: _____

Age: _____ Height: _____ Weight: _____ Ideal Weight: _____ Blood Type: _____

This questionnaire will help in the study of your present state of health. This information will assist me in choosing an appropriate direction to take in working toward creating your optimal level of health. Please answer each of the following questions:

Check if you eat, drink, or use (even occasionally):

□ Alcohol	□ Distilled Water	□ Sugar Substitutes
□ Candy	□ Fried Foods	□ Chewing Gum
□ Luncheon Meats	□ Carbonated Beverages	□ Fast Foods
□ White Flour	□ Margarine	□ Vitamins/Minerals
□ Chocolate	□ Potato Chips	□ Refined Sugars
□ Spring Water	□ Aluminum Pans	□ Microwave Oven

How many cups/bottles/glasses do you drink, on average, per day?

Coffee: ___	Tea: ___	Water: ___	Milk: ___
Milk 2%: ___	Fruit Juice: ___	Soft Drinks (diet): ___	Soft Drinks (reg): ___
Vegetable Juice: ___	Herbal Tea: ___	Beer: ___	Wine: ___
Liquor: ___			

How often do you have an alcoholic beverage? _____
Have you ever been treated for alcoholism? _____

Do you smoke? **YES** **NO**
If so, how many cigarettes/cigars per day? _____
Have you ever smoked? _____ For how long? _____
Does anyone smoke in your household? _____ Your workplace? _____

How many hours of sleep do you get on average? _____
Do you awaken feeling rested? _____

How many hours do you work each day? _____
Do you enjoy your work? _____

Activity Level:
- □ Sedentary (no exercise- gardening or housework etc.)
- □ Moderately active (3-5 times/week, 20-30min each time)
- □ Active (3-5 times/week 60min each time)
- □ Very active (3-5 times/week 90min each time- Competitive Recreational Athletes)
- □ Extremely Active (5 or more times/week 90min plus per session- Pro Athletic Level)

List types of exercise: _____
How many hours a day do you watch television? _____
How many hours do you read? _____

How many hours do you spend in front of a computer? _____
What are your main hobbies and recreation?

_____
_____

Do you take vitamins regularly? _____
When was your last vacation? _____

What level of stress are you experiencing right now?

□	Minimal	□	Considerable
□	Average	□	Unbearable

Is your main stress:

□	Financial	□	Health
□	Job-related	□	Unfulfilled Expectations
□	Interpersonal	□	Family Members
□	Marriage	□	Spiritual

What are you taking now? (Vitamins, Minerals, Herbal Remedies, Prescription Drugs, etc.)

_____
_____
_____
_____

Family History:
Hereditary Diseases:

Health of Relatives:
Father: _____
Mother: _____
Siblings: _____

Have you ever been hospitalized? _____
What was the reason? _____

Dietary Habits: List what you ate and drank at your **last three meals**:

Breakfast:

_____
_____
_____

Lunch:

_____
_____
_____

Dinner:

_____
_____
_____

Snacks:

_____
_____
_____