

# Rockwell Nutrition Questionnaire

[www.RockwellNutrition-Canada.com](http://www.RockwellNutrition-Canada.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. \_\_\_\_\_

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**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