Patient Name:
Date of Birth:
Today's Date:

Advanced Musculoskeletal Medicine Consultants, Inc.

NUTRITIONAL QUESTIONNAIRE:

Please answer the following questions to the best of your ability. Please return this as well as your 2-WEEK DIET JOURNAL and YOUR MARK UP OF THE ANTI-INFLAMMATORY DIET SHEET at least two days before your nutritional assessment appointment. Thank you! Dr Delzell

1. Would you consider yourself a picky eater?	YES	NO
2. Are there particular foods that do not agree with you? If YES, Please list_____	YES	NO
3. Are there foods that you absolutely cannot live without? If YES, Please list_____	YES	NO
4. Do any foods make you sick, give you a stomachache or nauseated? If YES, Please list_____	YES	NO
5. Do you enjoy cooking?	YES	NO
6. Do you have time to cook?	YES	NO
7. How easy is it for you to have a meal in your home that everyone will enjoy?	YES	NO
8. Is eating a joyful experience for you?	YES	NO
9. What do you like to snack on? _____		
10. How close to bedtime do you eat? _____		
11. Do you experience heartburn?	YES	NO
12. Do you consider food medicine?	YES	NO
13. Do you consider food fuel for your body?	YES	NO
14. Do you consider food fuel for your brain?	YES	NO
15. Do you diet?	YES	NO
16. Do you understand the difference between carbohydrates, protein, and fat?	YES	NO
17. Do you know what a healthy fat is?	YES	NO
18. Do you know the difference between a simple carbohydrate and a complex carbohydrate?	YES	NO
19. Do you count calories?	YES	NO
20. Do you sit down to eat?	YES	NO
21. Do you have any food allergies? If YES, Please list_____	YES	NO
22. Do you know what nutrient-dense foods are? If NO, Please explain_____	YES	NO
23. Are your bowel movements normal?	YES	NO
24. Do you drink caffeine? If YES, what, how often and what time of day_____	YES	NO