FOLLOW-UP QUESTIONNAIRE

Name: _____
Appointment Date:_____

Please submit this entire follow up questionnaire 48 hours before your next visit. If you are unable, we will go through this at your next visit and this will limit the time available to work on a new plan. My goal is to support you in making the best choices for your health.

Follow up Questions:

1. What is your primary health goal? _____
2. What symptoms or issues are you dealing with that you would like to address? _____
3. What has improved since your last visit? _____
4. What has NOT improved or worsened since your last visit? _____
5. What major events have occurred in your life since your last visit? _____
6. What obstacles (external barriers or competing demands) have you faced in following your health plan since your last visit? _____
7. Rate how willing you are, on a scale of 1 (not willing) to 5 (very willing) to:
    1. Modify your diet: _____
    2. Take supplements daily: _____
    3. Keep a food journal periodically: _____
    4. Adjust your lifestyle (work demands, sleep habits): _____
    5. Practice relaxation techniques: _____
    6. Engage in regular exercise: _____
8. Interventions you incorporated into your life since last visit related to:
    A. Sleep:_____
    B. Stress:_____
    C. Self Care:*_____
    D. Diet:_____
    E. Exercise:_____

Medication/supplement Update:

Name	Dose	Frequency	Reason

***Self care ideas:** 4x deep breathing, meditation/prayer, wind down routine at night, 5 min wake up routine, time with friends/by yourself

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Medical Symptoms Questionnaire – MSQ

Rate each of the following symptoms based upon your typical health profile for the past 14 days.
POINT SCALE:
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

Digestive Tract
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Heartburn
_____ Intestinal/Stomach pain
_____ Total

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ Total

Emotions
_____ Mood swings
_____ Anxiety, fear or nervousness
_____ Anger, irritability or aggressiveness
_____ Depression
_____ Total

Energy/Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ Total

Eyes
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or farsightedness)
_____ Total

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ Total

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ Total

Joint/Muscles
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ Total

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficult breathing
_____ Total

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ Total

Mouth/Throat
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen/discolored tongue, gum, lips
_____ Canker sores
_____ Total

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ Total

Skin
_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair loss
_____ Flushing or hot flushes
_____ Excessive sweating
_____ Total

Weight
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ Total

Other
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ Total

_____ **GRAND TOTAL**

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3 Day Food Journal: Food is often our best medicine! Please complete this follow up food journal as honestly as possible so I can help you adjust your nutrition to maximize symptom improvement whenever possible.

Here are some tips for providing the most helpful information:

- **Record what you ate OR drank as soon as possible after each time you eat/drink, including water**
- **Don't change your usual eating behaviors**
- **Describe the food or beverage consumed. e.g., milk (whole, 2%); toast (whole wheat, white); chicken (fried, baked, breaded)**
- **Record amount of each food consumed using standard measurements, such as 8 ounces, 1/2 cup, 1 t**
- **Include any added items, example: tea with 1 t sugar, potato with 2 t butter**
- **Record how you felt within 2 hrs of eating/drinking, note if you felt well or if you noticed any symptoms.**

DAY 1	Food & Drink Intake (type and amount)	Felt within 2 hours of Eating (hungry, tired, achey, bloated)	What were you doing when you ate
Wake time:			
Breakfast: Time:			
Mid AM snack Time:			
Lunch Time:			
Mid PM Snack Time:			
Dinner Time:			
PM Snack Time:			
Exercise/ Self-care:			
Bedtime:			

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DAY 2	Food & Drink Intake (type and amount)	Felt within 2 hours of Eating (hungry, tired, achey, bloated)	What were you doing when you ate
Wake time:			
Breakfast: Time:			
Mid AM snack Time:			
Lunch Time:			
Mid PM Snack Time:			
Dinner Time:			
PM Snack Time:			
Exercise/ self-care:			
Bedtime:			

DAY 3	Food & Drink Intake (type and amount)	Felt within 2 hours of Eating (hungry, tired, achey, bloated)	What were you doing when you ate
Wake time:			
Breakfast: Time:			
Mid AM snack Time:			
Lunch Time:			
Mid PM Snack Time:			
Dinner Time:			
PM Snack Time:			
Exercise/ Self-care:			
Bedtime:			