Awesome Nutrition Questionnaire

Name:_____ **Date:**_____

Part 1: Symptoms -

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom
1 Occasionally have it, effect is not severe
2 Occasionally have it, effect is severe
3 Frequently have it, effect is not severe
4 Frequently have it, effect is severe

Digestive Tract

Nausea, vomiting	0 1 2 3 4
Diarrhea	0 1 2 3 4
Constipation	0 1 2 3 4
Bloated feeling	0 1 2 3 4
Heartburn	0 1 2 3 4
Intestinal, stomach pain	0 1 2 3 4

Digestive Total: 0

Joint/ Muscles

Pain or aches in joints	0 1 2 3 4
Arthritis, joint swelling	0 1 2 3 4
Stiff or limitation of movement	0 1 2 3 4
Pain or aches in muscles	0 1 2 3 4
Feeling of weakness or tired	0 1 2 3 4

Joints/ Muscles Total: 0

Emotional

Mood swings	0 1 2 3 4
Anxiety, fear, nervousness	0 1 2 3 4
Anger, irritability aggression,	0 1 2 3 4
Depression	0 1 2 3 4

Emotional Total: 0

Weight/ Food

Binge eating, drinking	0 1 2 3 4
Craving certain foods	0 1 2 3 4
Excessive weight	0 1 2 3 4
Compulsive eating, food addictions	0 1 2 3 4
Water retention	0 1 2 3 4
Underweight	0 1 2 3 4

Weight/ Food Total: 0

Energy/ Fatigue

Fatigue, sluggishness	0 1 2 3 4
Apathy, lethargy	0 1 2 3 4
Hyperactivity	0 1 2 3 4
Restlessness, achiness	0 1 2 3 4
Sleep disturbances	0 1 2 3 4

Energy/ Sleep Total: 0

Skin

Acne	0 1 2 3 4
Hives, rashes, dry skin, redness	0 1 2 3 4
Hair loss	0 1 2 3 4
Flushing, hot flashes	0 1 2 3 4
Excessive sweating	0 1 2 3 4

Skin Total: 0

Heart

Irregular or skipped heartbeat	0 1 2 3 4
Rapid or pounding heartbeat	0 1 2 3 4
Chest pain	0 1 2 3 4

Heart Total: 0

Other

Frequent illness	0 1 2 3 4
Frequent or urgent urination	0 1 2 3 4
Genital itch or discharge	0 1 2 3 4

Other Total: 0

Respiratory

Chest congestion	0 1 2 3 4
Asthma, bronchitis	0 1 2 3 4
Shortness of breath	0 1 2 3 4
Difficulty breathing	0 1 2 3 4

Respiratory Total: 0

Eyes

Watery or itchy eyes	0 1 2 3 4
Swollen, red, or sticky eyelids	0 1 2 3 4
Bags or dark circles under eyes	0 1 2 3 4
Blurred or restricted vision	0 1 2 3 4

Eyes Total: 0

Nose

Stuffy nose	⓪ ① ② ③ ④
Sinus problems or dripping nose	⓪ ① ② ③ ④
Hay fever	⓪ ① ② ③ ④
Sneezing attacks	⓪ ① ② ③ ④
Excessive mucus	⓪ ① ② ③ ④

Nose Total: 0

Mouth/ Throat

Frequent, consistent coughing	⓪ ① ② ③ ④
Gagging, need to clear throat	⓪ ① ② ③ ④
Sore throat, hoarse, loss of voice	⓪ ① ② ③ ④
Swollen or discolored tongue, gums, or lips	⓪ ① ② ③ ④
Canker sores, other mouth sores	⓪ ① ② ③ ④

Mouth/ Throat Total: 0

Ears

Itchy ears	⓪ ① ② ③ ④
Earaches, ear infections	⓪ ① ② ③ ④
Drainage from ear, waxy buildup	⓪ ① ② ③ ④
Ringing in ears, hearing loss	⓪ ① ② ③ ④

Ears Total: 0

Head

Headaches	⓪ ① ② ③ ④
Faintness or lightheadedness	⓪ ① ② ③ ④
Dizziness	⓪ ① ② ③ ④

Head Total: 0

Cognitive

Poor memory, recall	⓪ ① ② ③ ④
Confusion, poor comprehension	⓪ ① ② ③ ④
Poor concentration	⓪ ① ② ③ ④
Poor physical coordination	⓪ ① ② ③ ④
Difficulty in making decisions	⓪ ① ② ③ ④
Stuttering, stammering	⓪ ① ② ③ ④
Slurred speech	⓪ ① ② ③ ④
Learning disabilities	⓪ ① ② ③ ④

Cognitive Total: 0

Grand Total: 0

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

◎ Yes (1 pt.) ◎ No (0 pt.) If yes, how many are you currently taking?_____ (1pt. each)

2. Are you presently taking one or more of the following over- the- counter drugs?

◎ Cimetidine (2 pts) ◎ Estradiol (2 pts) ◎ Acetaminophen (2 pts.)

3. If you have used or currenlty use prescription drugs, which of the following scenarios best represents your response to them:

◎ Experience side effects; drug(s) is (are) efficacious at lowered dose(s)(3 pts.)
◎ Experience side effects; drug(s) is (are) efficacious at usual dose(s)(2 pts.)
◎ Experience no side effects; drug(s) is (are) usually not efficacious(2 pts.)
◎ Experience no side effects; drug(s) is (are) efficacious (0 pts.)

4. Do you currently (within the last 6 months) or have a regularly used tobacco products? ◎ Yes (2 pt.) ◎ No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine- containing products?

◎ Yes (1 pt.) ◎ No (0 pt.) ◎ Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness? ◎ Yes (1 pt.) ◎ No (0 pt.)

7. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors

◎ Yes (1 pt.) ◎ No (0 pt.) ◎ Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

◎ Yes (1 pt.) ◎ No (0 pt.) ◎ Don't know (0 pt.)

9. Do you have a personal history of:

◎ Environmental and/ or chemical sensitivities(5 pts.)
◎ Chronic fatigue symptoms (5 pts.)
◎ Multiple chemical sensitivity (5 pts.)
◎ Fibromyalgia (3 pts.)
◎ Parkinson's type symptoms (3 pts.)
◎ Alcohol or chemical dependence (2 pts.)
◎ Asthma (1 pts.)

10. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

◎ Yes (1 pt.) ◎ No (0 pt.)

11. Do you have an adverse of allergic reaction when you consume sulfite- containing foods such as wine, dried fruit, salad bar vegetables, etc.?

◎ Yes (1 pt.) ◎ No (0 pt.) ◎ Don't know (0 pt.)

Total: 0

Part 3: Alkalizing Assessment

1. Do you have a history of or currently have kidney dysfunction? ◎ Yes (1 pt.) ◎ No (0 pt.)
2. Have you ever been dianosed with hyperkalemia? ◎ Yes (1 pt.) ◎ No (0 pt.)
3. Are you currently taking diuretics of blood pressure medication? ◎ Yes (1 pt.) ◎ No (0 pt.)

Total: 0

Additional Questions

1. Please list the supplements you are currently taking daily:

2. How much do you believe you are spending a month on nutrition?

◎ $0- $50
◎ $50-$100
◎ $100- $200
◎ $200+

3. How much do you want to spend a month on nutrition?

◎ $0- $50
◎ $50-$100
◎ $100- $200
◎ $200+

With the following information we will create a customized Awesome Nutrition plan for you.

Overall Score Tabulation

FOR PRACTITIONER USE ONLY:

Part 1:Symptoms Grand Total_____0_____ (high>50; moderate 15-49, low <14)
Part 2: XXT Total _____0_____ (high>10; moderate 5-9, low <4)
Part 3: Alkalizing Assessment Total_____0_____ (high≥1; moderate 5-9, low <4)
Urinary pH _____

*Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any conditions or illness. All medical symptoms should be addressed by a qualified medical professional