

CASCADIA WELLNESS CLINIC
 14670 NE 8th St. Suite #215
 Bellevue, WA 98007
 425-746-4045

Nutritional Questionnaire

Name: _____

Date: _____

To help me better understand how your eating practices may be affecting your health, I would appreciate you taking a few minutes to complete this questionnaire. Please check off your answer to each question as accurately as you can. Thank you.

Questions	Never	Occasionally	Regularly
Do you eat breakfast?			
Do you eat lunch?			
Do you eat dinner?			
Do you follow a food combining program?			
Do you eat red meat?			
Do you eat white meat & fish?			
Does your daily diet include fruit?			
Does your daily diet include vegetables?			
Do you drink soft drinks?			
Do you drink diet soft drinks?			
Do you use artificial sweeteners?			
Do you drink coffee or tea?			
Do you drink tap water?			
Do you take prescription drugs?			
Do you take over-the-counter medicines?			
Do you take antacids?			
Do you have sugar cravings?			
Do you read labels for fat content?			
Do you eat foods with MSG?			
Do you take vitamin supplements?			
Do you eat deep fried foods?			
Do you eat chocolate?			
Do you consume dairy products inc. ice cream?			
Do you snack on "junk foods"?			
Do you drink alcoholic beverages?			
Do you smoke or chew tobacco?			
Are you exposed to second hand smoke?			
Do you eat out in restaurants?			
Do you have allergic reactions to foods?			
Would you like to weigh less?			
Would you like to weigh more?			
Do you snack between meals?			
Do you experience intestinal gas after eating?			
Do you experience any digestive discomfort?			

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Stress Questionnaire

Name: _____

Date: _____

To help me understand how your stress level may be affecting your health, I would appreciate you taking just a few minutes to complete this questionnaire. Please check off your answer to each question as accurately as you can as it applies to your life within the last 12 months. Thank you.

Questions	No	Yes
Do you regularly perform aerobic exercise?		
Do you feel stress is a big factor in your life?		
Are you regularly exposed to airborne pollutants or toxins?		
Do you use a computer?		
Do you microwave your food?		
Do you live or work near high voltage power lines?		
Has a family member or friend died in the last year?		
Have you married, separated or divorced in the last year?		
Are you or a family member experiencing any health problems?		
Do you have ongoing relationship challenges?		
Are you experiencing financial pressures?		
Have you or a family member lost a job recently?		
Have you moved to a new home or position at work?		
Do you have boss or work challenges?		
Are you retired or contemplating retirement?		
Have you or a family member started a new job recently?		
Have your sleep patterns changed?		
Have your eating habits changed?		
Are you starting or ending a school year?		
Have you recently purchased or sold your home?		
Have you assumed more or less responsibilities at work?		
Has your social life changed significantly?		
Are you experiencing any legal problems?		
Are you expecting or have a new baby in the family?		
Have any older children left home?		
Are vacations and holidays happy times?		
Have your recreation patterns changed?		
Can you relax after work?		
Is substance abuse a factor in your or a family member's life?		