



Please understand that nutritional services are not intended as diagnosis, prescription, treatment or cure for any disease and is not intended as a substitute for regular medical care.

Nutrition Assessment Questionnaire

Please answer the following questions about your medical history to help the nutritionist assess your current state of health. The accuracy of your answers is vital to ensuring your personalized nutrition plan will meet all of your specific needs.

Date you are completing this questionnaire _____

Personal Profile

Name: _____ Birthdate: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Email: _____

Any known Allergies (include Dietary): _____

Age: _____ Height: _____ Weight: _____ Usual Body Weight: _____

Weight loss? Yes No Amount? _____ Over what period of time? _____

Lifestyle Profile

What is/was your occupation? _____

What are your hobbies? _____

Do you exercise? Yes No Describe _____

Do you smoke? Yes No Describe _____

How do you relieve stress? _____

Please list any specific issues you would like the nutritionist to address:

(1) _____

(2) _____

(3) _____

How did you hear about this service? _____

Medical Profile

What is your cancer diagnosis? _____

When was your diagnosis: _____

Have you had surgery? Yes No Briefly Describe _____

Are you on chemotherapy? Yes No Type _____

Duration: _____

Are you on radiation? Yes No Duration: _____

Is there any other pertinent information relating to your cancer treatment you would like the nutritionist to know about? _____

Please check any other medical conditions you have *or have had* in the last 10 years:

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Stomach ulcers, colitis | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis, Liver disease |
| <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Blood disorder | <input type="checkbox"/> Cardiovascular Disease |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Epilepsy, Seizures |

List all current prescription medications: Attach separate sheet if necessary.

<u>Name</u>	<u>Dosage</u>	<u>For Which Condition</u>
-------------	---------------	----------------------------

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physical Profile

Do you experience any of the following conditions on a regular basis?

- | | | | |
|----------------------|--|---------------------------------------|--|
| Decreased appetite? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Vomiting? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Constipation? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Nausea? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diarrhea? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Mouth sores? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Taste/Smell changes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pain? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Where? _____ | |
| Fatigue? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please rate on a scale of 1-10* _____ | |
| Stress? | <input type="checkbox"/> Yes <input type="checkbox"/> No | Please rate on a scale of 1-10* _____ | |

*Use "1" to indicate "No fatigue or stress" and "10" to indicate "An extreme amount of fatigue or stress."

Laboratory Data

Complete Blood Count and Chemistry Screen Panel must be **drawn within the past 30 days.*

<p>What is a Chemistry Screen Panel? Also know as a Comprehensive Metabolic Panel, contains the following lab values:</p> <p>Glucose Renal Labs such as: BUN Creatinine Liver Enzymes such as: SGOT/AST SPGT/ALT Total Protein If possible-include lipid profile: Cholesterol Triglyceride LDL HDL VLDL</p> <p>Albumin Minerals: Ca (calcium) Mg (magnesium) Electrolytes such as: NA (sodium) K (potassium) Cl (chloride)</p>	<p>What is a Complete Blood Count (CBC)? A CBC contains the following lab values:</p> <p>White Blood Count (WBC) Red Blood Count (RBC) Hemoglobin (HGB) Hematocrit (HCT) MCV MCH MCHC Retic Platelets (Plat)</p> <p>Differentials: Grans Poly Band Meta Lymph Mono Eos Baso Alymph</p>
---	---

Nutrition Profile

Briefly describe:

- Are you on intravenous or tube feedings? Yes No _____
- Do you take high calorie/protein drinks? Yes No _____
- Do you take Laxatives/Stool Softeners? Yes No _____

Please list any vitamins, herbs or other supplements you take on a regular basis.
Attach a separate sheet if necessary.

<u>Name of product</u>	<u>Dosage</u>	<u>How often do you take it?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food Frequency

My regular diet includes:

- _____ servings of fish per week _____ servings of fruits & vegetables per day
- _____ servings of water per day _____ servings of whole grain products per day.
- _____ servings of soy foods per week.

Service Options

Check one:

- Question and Answer (\$30.00 for 15 minute session)
- Nutrition counseling (\$80.00 for 30 minute session)
- Diet Supplement counseling (\$100.00 for 30 minute session)
- Diet & Vitamin program counseling (\$175.00 for 60 minute session)
- Follow-up counseling (\$30.00 for 15 minute session)

Please read and sign the following statement:

I, _____ understand that there is a charge for various Nutrition Services. Medicare and most insurance companies do not cover nutritional counseling. I understand this, and agree to be personally and fully responsible for the fee of the service I have chosen above.

Signature _____

Payment Options

Check one:

- Check /Money Order (sent with questionnaire)
- Credit Card: Visa Master Card Discover Exp. Date: _____

Card Number: _____

Name as it appears on Card: _____

Billing address: _____

Signature: _____

**Prepayment is required to secure your appointment date.
Personal Checks or Credit Cards Accepted.**

Return Instructions

Please return completed questionnaire, payment and lab work to:

Mail: Cancer Resource Center – Attn: HNS *Fax:* 847-662-4791
6170 W. Grand Ave, Ste 197
Gurnee, IL 60031

Please call 1-800-940-2822 for any questions you might have.