Valarie Haag, N.D.
Nutrition Assessment Questionnaire

www.rainbowsofhealing.com
(215) 736-3803

General Information:

Name: _____ Date_____

Address: _____
Street City State Zip Code

Home Phone #: _____ Work/Cell #: _____ Blood Type: _____

E-mail: _____ Date of Birth: _____ Age: _____

Favorite Color: _____ Least Favorite Color: _____

Occupation: _____ Employer: _____

Referred by: _____

Medications currently using

_____

Supplements currently taking

_____

Five Most Significant Health Problems

_____

_____

Intention for consult:

_____

_____

_____

If you have a specific chief complaint, please describe (briefly).

_____

_____

How and when did the problem begin? :

_____

_____

Disclaimer
It is understood that the service provided by Dr. Valarie Haag is intended for educational purposes only. Dr. Valarie Haag shall have neither liability nor responsibility to any person or entity with respect to any loss, damage, or injury caused or alleged to be caused directly or indirectly by her services. Furthermore, the service provided is meant solely for educational and informational purposes only and is not intended to be prescriptive nor to replace the care of a qualified health care provider.

_____ _____
Signature **Date**

Valarie Haag, N.D.
Nutrition Assessment Questionnaire

www.rainbowsofhealing.com
(215) 736-3803

Circle any of the following item you consume:

Alcohol	Dairy products	Margarine
Candy or other sweets	Deep fried foods	Non-herbal tea
Chewing tobacco	Distilled water	Refined (white) flour products
Cigarettes	Fast food	Refined sugar
Cigars	Fluoridated/chlorinated water	Soft drinks
Coffee	Luncheon meats	

Instructions: Read the following symptoms and fill in the number that applies:

0 = Do not have the symptom, the symptom does not apply
1 = It is a minor symptom or it rarely occurs
2 = It is a moderate symptom or it occasionally occurs
3 = It is a significant symptom or it frequently occurs
4 = It is a severe symptom or you are aware of it almost constantly

Rate the severity or frequency of the symptom from 0 to 4. How significant is the symptom? How true is the statement—0 means not at all, 4 means extremely true. Where the question is answered by yes or no, circle Y or N.

1. _____ Fingernails chip, peel or break easily

2. _____ Belching or gas within 1 hr. of a meal

3. _____ Distaste for meat (not a vegetarian for moral other or other reasons)

4. _____ Fewer than one bowel movement per day

5. _____ Stools hard or difficult to pass

6. _____ Bloating after eating

7. _____ Only specific foods cause bloating

8. _____ Sleepy after eating

9. _____ Sensitive to smoke

10. _____ Feeling "wired" or jittery if drinking coffee

11. _____ Pain between the shoulder blades

12. _____ Bizarre, vivid or nightmarish dreams

13. _____ Metallic taste in the mouth

14. _____ Bitter taste in mouth, especially after meals

15. _____ Become sick after drinking wine (as opposed to other alcoholic beverages)

16. _____ Wake up without remembering dreams

17. _____ Bothered if eating food with monosodium glutamate (MSG)

18. _____ Become intoxicated easily if drinking alcohol

19. _____ Severe hangovers after drinking alcohol

20. _____ Trouble tolerating greasy foods

21. _____ Trouble tolerating aspartame (Nutrasweet)

22. _____ Frequent fevers

23. _____ Trouble tolerating garlic or onions

24. _____ Gallbladder attacks (past or present)

25. _____ Urine has a strong odor

26. _____ Dry flaky skin or dandruff

27. _____ Sensitive to chemicals (perfume, insecticides, exhaust fumes)

28. _____ Hemorrhoids or varicose veins

29. _____ Take over the counter pain medication

30. Y N Aspirin is an effective pain reliever

31. _____ Sweat a lot

32. _____ Sweat at night

33. _____ Feet have a strong odor or sweat easily

34. _____ Lower bowel gas

35. _____ Alternating constipation/diarrhea

36. _____ Nausea

37. _____ Epigastric (top of stomach) burning or gastric reflux

38. _____ Patches of dry skin, eczema or psoriasis

39. _____ Hair breaks or falls out easily

40. _____ Anus itches

41. _____ Coated tongue

42. _____ Lactose intolerant

43. _____ Colitis, irritable bowel or Crohn's disease

44. _____ Crave sugar

45. _____ Eat a dessert with sugar, donut, soft drink, ice cream etc. (1 = 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day)

46. _____ Crave bread or noodles

47. _____ Eat refined white flour products (French, Italian or other white bread, bagels, pasta etc.) [1= 1x/week; 2 = 2-3x/week; 3 = daily or almost daily; 4 = more than 1x/day]

48. _____ Are there any foods that you feel that you would not want to give up? (Think of foods that you eat every day like bread, cheese etc.)

49. _____ Have you taken tetracyclines (Sumycin, Panmycin Vibramycin, Minocin) for acne? [1 = 1 mo.; 2 = 2 mo.; 3 = 3 mo.; 4 = 4 mo. or longer]

50. _____ Have you taken broad-spectrum antibiotics for urinary, respiratory or other infection? (1 = 1 course < 2 mo.; 2 = 1 course 2 mo. or longer; 3 = 2x in a single year; 4 = more than 2x in a single year)

51. _____ Hay fever or seasonal allergies

52. _____ Feel worse when in a moldy or musty place

53. _____ Sinusitis (nose stuffy, sinus headaches or sinus infections)

54. _____ Runny or drippy nose

55. _____ Catch colds at the beginning of winter

56. _____ Migraine headaches

57. _____ Binge eating or uncontrolled eating

58. _____ Asthma, wheezing or difficulty breathing

59. _____ Crave coffee or sugar in the afternoon

60. _____ Afternoon headaches

61. _____ Fatigue that is relieved by eating

62. _____ Shaky, headachy, or tired when meals are delayed

63. _____ Family history of diabetes (1 = distant relative; 2 = 1 or 2 direct relatives; 3 = 3 or 4 direct relatives; 4 = more than 4 direct relatives)

64. _____ Frequent thirst

65. _____ Cuts take a long time to heal

66. _____ Frequent urination

67. _____ Frequent infections

68. _____ Numbness or tingling in the extremities

69. _____ Fatigue

70. _____ Cry, become teary or sad for no reason

71. _____ Ankles swell

72. _____ Become cold easily or when others are not

73. _____ Depression

74. _____ If #73 is a symptom of yours, can you characterize your depression as feeling "low" with a strong desire to sleep, sleeping a lot and having trouble getting out of bed

75. _____ If #73 is a symptom, can you characterize your depression as feeling agitated, anxious or having difficulty falling and staying asleep

76. _____ Lack of motivation (function from day to day but lacking initiative)

77. _____ Brittle, coarse hair

78. _____ Difficulty losing weight

79. _____ Frequent colds or the flu

80. _____ Frequent diets (reducing food intake) (1=1 or 2; 2=3 or 4; 3 = 5 or 6; 4 = 7 or more)

81. _____ Crave salt or salty foods

82. _____ Crave greasy or fatty foods

83. _____ Pain on the inside (medial) knee or on one side of the low back

84. _____ Become dizzy when standing up suddenly

85. _____ Trouble getting out of bed in the morning

86. _____ Tend to be a "night" person

87. _____ Tendency to worry

88. _____ Tend to be calm on the outside, troubled inside

89. _____ Changed marital status (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

90. _____ Death of a loved one. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

91. _____ Changed jobs, lost a job or started a new job. (1=w/in 2 years; 2= w/in 1 year; 3= w/in 6 mos.; 4 = w/in 3 mos.)

92. _____ How many hours do your work each week? (1= 45 or less; 2= 45-50; 3= 50-55; 4=more than 55)

93. _____ Keyed up, trouble calming down.

94. _____ Fall asleep only to wake up after a few hours and have trouble falling back to sleep

95. _____ Difficulty falling asleep

96. _____ Feelings of insecurity

97. _____ Heart races or palpitates

98. _____ Clench or grind teeth

99. _____ Jaw clicks, pops, locks or makes noise

100. _____ Tension headaches (base of skull)

101. _____ Headaches when hot or out in the sun

102. _____ Get up at night to urinate

103. _____ Decreased ability to taste or smell

104. _____ Get hives

105. _____ Acne

106. _____ Undigested food in stool

107. _____ Taken birth control pills (1= 6 mos. or less ; 2= 1 yr. or less; 3= 1-2 yrs.; 4= more than 2 yrs.)

108. _____ Feel spacey or unreal

109. _____ Rehabilitated or done construction in a house built before 1970 (1= yes, but didn't live there during work; 2= lived there when the work was done; 3= rehabbed more than 1; 4= lived in more than 1 house that's been rehabbed)

110. _____ Fungus or yeast infections

111. _____ Exposure to diesel fumes

112. _____ Do you smoke , how many pack-years (number of years times the number of packs per day)? [1=2 or less; 2=3-5; 3=7-10 and 4= more than 10 pack-years]

113. _____ Did you quit smoking (1= more than 10 yrs ago; 2= 5-10 yrs.; 3=1-5 yrs.; 4= less than 1yr)

114. _____ How many alcoholic beverages each week? (1= 1-7; 2= 8-14; 3= 14-21; 4= more than 21 alcoholic beverages per week)

115. Y N Are you a recovering alcoholic?

116. Y N History of anorexia or bulimia

117. _____ How many mercury (silver) fillings (1= 1-2; 2= 3-5; 3= 6-7; 4= more than 7 fillings)

118. _____ Have you taken shark cartilage? (mark 1 point for every 3 months on the supplement)

119. Y N Diagnosed with chronic fatigue syndrome or fibromyalgia

120. _____ Pain or swelling in the joints

121. _____ Muscles become easily fatigued

122. _____ Anemia that is unresponsive to iron

123. _____ Greasy or shiny stools

124. _____ Clay-colored stools

125. _____ Stomach upset by taking vitamins

126. _____ Hands tremble

127. _____ Calves cramp at night

128. _____ Legs cramp after walking, better after rest

129. _____ Undigested fat in stool

130. _____ (Women) Anxiety, irritability, emotional instability related to menstrual cycle

131. _____ (Women) Depression during period

132. _____ (Women) Weight gain greater than 3 pounds and/or abdominal bloating associated with cycle

133. _____ (Women) Breast tenderness, soreness or swelling associated with cycle

134. _____ (Women) Excess menstrual flow

135. _____ (Women) Sugar, chocolate, or carbohydrate craving associated with cycle

136. _____ Dark circles under the eyes

137. _____ Sense of fullness after meals

138. _____ Do not feel like eating breakfast

139. _____ Feel better if you don't eat

140. _____ Black or tarry stools

141. _____ Pain under right side of ribcage

142. _____ Itchy skin (maybe worse at night)

143. _____ Cold sores, fever blisters or Herpes lesions

144. _____ Sunburn easily or get "sun poisoning"

145. _____ Cough that produces mucus

146. _____ Bruise easily

147. _____ Frequent infections (ear, bladder, lung etc.)

148. _____ Eyes sensitive to bright light

149. _____ Exercise makes you feel worse

150. _____ Blush or face turns red for no reason

151. _____ Pain in chest, left arm or left side of neck

152. _____ Sigh frequently, air hunger or trouble catching breath

153. _____ Fluid retention

154. _____ (Men) Dribble after voiding urine

155. _____ (Men) Frequent urination or urgency to urinate

156. _____ (Men) Interruption of the stream during urination

157. _____ Pain or burning when urinating

158. _____ Bloody, cloudy and/or darkened urine

159. _____ Decreased libido

160. _____ Decreased scalp hair (not pattern baldness)

161. _____ Increased body hair

162. **Y N** Under 4' 10" tall

163. **Y N** Over 6' 6" tall

164. **Y N** Early sexual development

165. _____ Brittle hair that breaks easily

166. _____ Exercise (1= daily; 2= 4x/week or more; 3= 1-3x/week; 4= 1x/week or less)

167. **Y N** (Women) Irregular (non-cancerous) cells found on a PAP smear

168. **Y N** Have you ever had polyps?

169. **Y N** Use of antidepressant medication?

170. **Y N** Have the drugs (in #169) helped?

171. _____ Anxiety

172. **Y N** Use of anti-anxiety medication

173. **Y N** Has anti-anxiety medication helped?

174. _____ Tightness across the shoulder

175. _____ Stiff in the morning

176. _____ Joints are stiff and swollen

177. _____ Bursitis or tendonitis

178. **Y N** Have you ever had a herniated disc

179. _____ Flexible joints or "double jointed"

180. _____ Joints click or pop

181. **Y N** History of stress fractures

182. _____ Bone loss (reduced density on bone scan, loss of height, etc.)

183. **Y N** Are you shorter than you used to be?

184. **Y N** History of kidney stones (or family tendency for kidney stones)

185. **Y N** Yellow in the whites of the eyes

186. _____ (Women) Occasionally skip periods

187. _____ (Women) Excess facial hair

188. _____ (Women) Painful to have sexual intercourse

189. _____ (Women) Bleeding between periods

190. _____ (Women over 35) Irregular menstrual cycle

191. _____ (Women over 35) Hot flashes

192. _____ (Women over 35) Decrease in libido as getting older

193. _____ (Women) Vaginal discharge

194. _____ (Women) Poor concentration associated with certain times of menstrual cycle

195. _____ (Women) Vaginal itching or dryness

196. **Y N** (Women) Are you taking hormone replacement

197. **Y N** Women) Have you had a partial hysterectomy

198. **Y N** (Women) Have you had a total hysterectomy

199. _____ (Women) Cysts in breasts

200. _____ (Women) Ovarian cysts

201. _____ (Women) Scanty blood flow during period

202. **Y N** Take synthroid or other thyroid hormone

203. **Y N** Are you a vegan (no dairy, meat, or fish)

204. _____ Nutrasweet (aspartame) consumption (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)

205. _____ Sweat has strong odor

206. **Y N** Do you have tinnitus (ringing in your ears)

207. _____ Do you consume margarine? (1= 1x/wk or less; 2= 2-3x/week; 3= 4-7x/week; 4= more than 1x daily)

208. _____ Small bumps on the back of the arm

209. _____ Trouble seeing at night

210. **Y N** Lateral 1/3 of eyebrows doesn't grow hair

211. _____ Eyes itch during hay fever season

212. _____ Rapid heart beat

213. _____ Anxious, nervous or jittery

214. _____ Bad breath

Valarie Haag, N.D.
Nutrition Assessment Questionnaire

www.rainbowsofhealing.com
(215) 736-3803

HEALTH HISTORY

Name _____ Date of Birth _____ Today's Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit — Date began

_____ _____

_____ _____

Date of last physical exam _____ Practitioner name and phone number _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis)

_____

Outcome _____

What types of therapy have you tried for this problem(s):

❑ diet modification ❑ fasting ❑ vitamin/mineral ❑ herbs ❑ homeopathy ❑ chiropractic ❑ acupuncture ❑ conventional drugs

❑ other _____

List current health problems for which you are being treated: _____

_____

Current medications (prescription or over-the-counter): _____

_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Operation, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: ❑ underweight ❑ overweight ❑ just right Your weight today _____

❑ Unintentional weight loss or gain of 10 pounds or more in the last three months

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, farmer, miner)

_____

❑ Corrective lenses ❑ Dentures ❑ Hearing aid ❑ Medical devices/prosthetics/implants, describe: _____

Recent changes in your ability to: ❑ see ❑ hear ❑ taste ❑ smell ❑ feel hot/cold sensations

❑ move around (sit upright, stand, walk, run, pick up things, swing your arms freely, turn your head, wiggle fingers)

Strong like for any of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Strong dislike for any one of the following flavors: ❑ sour ❑ bitter ❑ sweet ❑ rich/fatty ❑ spicy/pungent ❑ salty

Do you: ❑ Prefer warmth (i.e., food, drinks, weather etc.) ❑ Prefer cold (i.e., food, drinks, weather, etc.) ❑ No preference

Is your sleep disturbed at the same time each night? _____ If yes, what time? _____

Time of day you feel the most energy or the least symptoms:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Time of day you feel the worst or your symptoms are aggravated:

❑ 7 a.m. - 9 a.m. ❑ 9 a.m. - 11 a.m. ❑ 11 a.m. - 1 p.m.
❑ 1 p.m. - 3 p.m. ❑ 3 p.m. - 5 p.m. ❑ 5 p.m. - 7 p.m.
❑ 7 p.m. - 9 p.m. ❑ 9 p.m. - 11 p.m. ❑ 11 p.m. - 1 a.m.
❑ 1 a.m. - 3 a.m. ❑ 3 a.m. - 5 a.m. ❑ 5 a.m. - 7 a.m.

Do you experience any of these general symptoms EVERYDAY?

❑ Debilitating fatigue	❑ Shortness of breath	❑ Insomnia	❑ Constipation	❑ Chronic pain/inflammation
❑ Depression	❑ Panic attacks	❑ Nausea	❑ Fecal incontinence	❑ Bleeding
❑ Disinterest in sex	❑ Headaches	❑ Vomiting	❑ Urinary incontinence	❑ Discharge
❑ Disinterest in eating	❑ Dizziness	❑ Diarrhea	❑ Low grade fever	❑ Itching/rash

Valarie Haag, N.D.
Nutrition Assessment Questionnaire

www.rainbowsofhealing.com
(215) 736-3803

Medical History

- ❑ Arthritis
- ❑ Allergies/hayfever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other _____

_____

Medical (Men)

- ❑ BPH
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ STD

Other _____

_____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ PMS
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ STD

Other _____

Age of first period _____

Date of last gynecological exam ____

Mammogram ❑ + ❑ –

PAP ❑ + ❑ –

Form of birth control _____

# of children _____

# of pregnancies _____

❑ C-section _____

❑ Surgical menopause

❑ Menopause

Date of last menstrual cycle _____

Length of cycle ____ days

Interval of time between cycles ____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Family Health History (parents and siblings)

- ❑ Arthritis, rheumatoid
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other _____

Health Habits

- ❑ Tobacco:

Cigarettes: #/day _____

Cigars: #/day _____

- ❑ Alcohol:

Wine: #glasses/d or wk _____

Liquor: #ounces/d or wk _____

Beer: #glasses/d or wk _____

- ❑ Caffeine:

Coffee: #6 oz cups/d _____

Tea: #6 oz cups/d _____

Soda w/caffeine: #cans/d _____

Other sources _____

- ❑ Water: #glasses/d_____

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight lift
- ❑ Swim
- ❑ Box
- ❑ Yoga

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other _____

Food Frequency

Servings per day:

Fruits (citrus, melons, etc.) _____

Dark green or deep yellow/orange vegetables _____

Grains (unprocessed) _____

Beans, peas, legumes _____

Dairy, eggs _____

Meat, poultry, fish _____

Eating Habits

- ❑ Skip breakfast
- ❑ Two meals/day
- ❑ One meal/day
- ❑ Graze (small frequent meals)
- ❑ Food rotation
- ❑ Eat constantly whether hungry or not
- ❑ Generally eat on the run
- ❑ Add salt to food

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _____
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveritrol, etc.)
- ❑ Herbs - teas
- ❑ Herbs - extracts
- ❑ Chinese herbs
- ❑ Ayurvedic herbs
- ❑ Homeopathy
- ❑ Bach flowers
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (e.g., Ensure)

Other _____

Would you like to:

- ❑ Have more energy
- ❑ Be stronger
- ❑ Have more endurance
- ❑ Increase your sex drive
- ❑ Be thinner
- ❑ Be more muscular
- ❑ Improve your complexion
- ❑ Have stronger nails
- ❑ Have healthier hair
- ❑ Be less moody
- ❑ Be less depressed
- ❑ Be less indecisive
- ❑ Feel more motivated
- ❑ Be more organized
- ❑ Think more clearly and be more focused
- ❑ Improve memory
- ❑ Do better on tests in school
- ❑ Not be dependent on over-the-counter medications like aspirin, Tylenol, Benadryl, sleeping aids, etc.
- ❑ Stop using laxatives or stool softeners
- ❑ Be free of pain
- ❑ Sleep better
- ❑ Have agreeable breath
- ❑ Have agreeable body odor
- ❑ Have stronger teeth
- ❑ Get less colds and flus
- ❑ Get rid of your allergies
- ❑ Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc.)

Valarie Haag, N.D.
Nutrition Assessment Questionnaire
www.rainbowsofhealing.com
(215) 736-3803

Name_____ Start Date_____

FOOD INTAKE JOURNAL

	MON.	TUES.	WED.	THURS.	FRI.	SAT.	SUN.
BREAKFAST							
LUNCH							
DINNER							
BEVERAGES							
SNACKS							
EXERCISE							
BOWEL MOVEMENTS							

Additional Notes:_____

_____

_____

_____

_____

Valarie Haag, N.D.
Nutrition Assessment Questionnaire
www.rainbowsofhealing.com
(215) 736-3803

Nutritional Balancing Program Contract and Wavier

SUMMARY OF THE NUTRITIONAL BALANCING PROGRAM:
·Detailed personal health history assessment
·Extensive dietary consultation
·Guided nutrition with appropriate supplementation
·Regimented whole foods dietary plan
·Advanced natural health information
·Education on your health that will stay with you

AGENDA:
The integration of natural health protocols will be aimed at deepening your awareness of your own body. Attention will be focused on individualized nutritional regimens and healthy lifestyle changes. You will be educated on your current diet and nutrition and how the two together affect overall health.

FEE:
The fee for the Nutritional Balancing Program is $270.00. This includes a 1-hour Initial Consultation, 1-hour Profile Report Visit, and 2 ½-hour follow-up visits. This will also include contact via phone or e-mail should you need additional support. All appointments need to be scheduled in advance, and a 24-hour cancellation policy does apply. Broken appointments without 24 hour notice will be charged a $50.00 cancellation fee. It is your responsibility to stick to your schedule, and the 2 follow up appointments are void 3 months from the date that we review your profile report.

SUPPLEMENTS:
Nutritional supplements may be suggested according to your specific needs. Please note that anything you take should be discussed with your medical doctor if you are currently under their supervision. All supplements once open will not be accepted for a refund.

EXPANDED AND ON-GOING SESSIONS:
In addition to the aforementioned attention given in the Nutritional Balancing Program, Dr. Haag is also available for additional private consultations to discuss other health concerns in more specific detail if time allows. This may include a deeper assessment of chronic health issues beyond the scope of the initial consultation and nutritional counseling already provided. Additional consultation fees will be applied at the rate of $65 per hour, when scheduled at the same time of the 4-6 week office visit. Food Allergy Testing is also available for an additional fee.

VIBRATIONAL HEALING SESSIONS:
To accomplish complete healing of body, mind, and spirit, Vibrational Energy Healing Sessions are available as an adjunct to your Nutritional Balancing Program for an additional fee. A discounted "Package Rate" may apply. These sessions include Reiki Healing, Crystal and Color Balancing, Reflexology, and Aromatherapy. The same 24-hour cancellation policy applies to these sessions.

CLIENT AGREEMENT:
I (client) have read all of the information listed above. I understand that, by signing this document, I agree to the terms of the Nutritional Balancing Program provided by Dr. Valarie Haag (Board Certified Traditional Naturopath) as stated above. I understand that she is not my primary care physician, nor is she intending to act as such. I acknowledge that services provided by Dr. Haag are not to be interrupted as diagnosis, treatment, alleviation, or care of any disease of any kind in any way. I hereby authorize Dr. Haag to perform a Nutritional Analysis and develop a customized Nutritional Profile Report with suggestions of dietary, nutritional and lifestyle changes. This information is provided for my education, and how I choose to integrate it into my life is my responsibility. I understand that this is a Nutritional Program aimed at improving my health and that everyone responds differently to the program. Although most individuals respond positively to the program, I am aware that I may respond differently to the nutritional regimen, supplements, etc. provided in the program. I also hereby claim, by signing below, that I currently have no advanced or existing health condition that has not been brought to Dr. Haag's prior

attention that would threaten my own health. If such condition(s) do exist, I agree that I must discuss it with Dr. Haag prior to and bring an approved medical report from my doctor that releases me to participate in such a program.

I hereby attest that I am here as a client, and this and any subsequent visit, solely on my behalf.

_____Printed name of client

_____
Date

_____
Signature of client