Chi Nutrition Questionnaire

Sometimes, it is helpful in our client's' healing and empowerment process to include some amount of focus on "Chi Nutrition", bringing the balance of yin and yang qualities of the chi through our food and supplementation. This can contribute to as much 33-34% of your health improvement. As such, thank you for taking the time to answer the following questions as accurately as possible.

Please check all of the following nutritional practices with which you are familiar:

_____ Chi Nutrition ____ 5 Flavors _____ Food Sequencing _____ Food Combining

_____Vegan _____ Juicing

Do you have any regularly occurring digestive, metabolic or waste elimination difficulties that you did not identify in your Client History Questionnaire? If "yes", please describe: ________________________

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Flavors

Check the flavor(s) you often crave:

_____ Sour ____ Bitter _____ Sweet _____ Mildly Spicy _____Very Spicy _____Salty

Of the flavors you have checked, circle the one flavor you crave the most?

How often in a day do you eat each of the flavors you checked above:

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Please provide examples of each of the flavors you have identified:

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Meals

On a typical work day, what do you eat and what time do you usually eat them?

Meal	Time	Food Items
Breakfast		
Lunch		
Dinner		
Snack #1		

Snack #2		
Other		

Are there any days in the week that you stray from this meal plan? For example, are any of your weekend meals drastically different? If "yes", please describe: ___________________________________
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Relevant Health Issues

Do you have any food or supplement allergies? If "yes", please describe, and tell us what happens when you eat them: ____
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Beyond what you have already identified in your Client History Questionnaire and this one …

Have you been clinically diagnosed, or otherwise seem to struggle with, **headaches, light-headedness, dizziness and/or any neurological or behavioral health issues or symptoms**? If "yes", please describe, and if you have received a clinical diagnosis relating to this issue, state the diagnosis and when it was diagnosed by a medical professional:

Health Issue	**When Does It Start? How Long Does It Last? How Frequently?**	**Name of Diagnosed Condition**	**Date Clinically Diagnosed**

Check all of the following symptoms that you experience on a regular or ongoing basis:

___ Easily Fatigued	___ Scattered or Chaotic Energy	___ Confused/Muddled Thinking
___ Poor Focus/Concentration	___ Tired Eyes	___ Swelling Anywhere in Body
___ Frequent Coughing	___ Difficulty Breathing	___ Dry Throat
___ Dry Skin	___ Excessive Hair Loss	___ Joint Aches/Stiffness
___ Spine Ache/Stiffness	___ Nausea/Vomiting	___ Thirst/Dry Mouth
___ Excessive Appetite	___ Poor, or Lack of, Appetite	___ Digestive Gas/Bloating
___ Overheated in Body	___ Chills	___ Ruddy Complexion
___ Thin/Weak Finger/Toe Nails	___ Balance Difficulties	___ Cold Hands/Feet
___ Menstrual Issue	___ Libido Issue	___ Over/Under Weight
___ Frustrated/Angry	___ Anxious	___ Sad/Depressed
___ Worried	___ Fearful	___ Can't Feel/Express Emotions

___ Other (not identified anywhere else in these questionnaires):_________________________________

____

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Do you have any concerns relating to your body's ability to digest foods, metabolize nutrients and eliminate waste? If "yes", please share your concern with us: ___________________________________

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Do any of your father, mother, step-parents, siblings, step-siblings, children and/or children have nutritional concerns similar to any of yours? If "yes, please identify who they are and what the concerns are:

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Please complete prior to, and return this form at your next visit. Feel free to contact me with any questions that come up.

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