Nutrition Detective Questionnaire

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Medical Anthropologist and NY State Certified Clinical Nutritionist

Please circle the symptom(s) that you experience:

1. Black and blue easily
2. Gums bleed
3. Slow wound healing
4. Poor night vision
5. White spots on nails for no reason
6. Cracked skin behind ears
7. Loss of sense of taste
8. Cracks in skin of fingertips
9. Yellow cast to face and skin
10. Muscle cramps or tremors
11. Enlarged thyroid gland
12. Burning feet
13. Crave sweets
14. Anemic
15. Pale tongue and pale inner eye lid
16. Break bones easily
17. Nocturnal leg cramps
18. Receding gums
19. Periodontal disease
20. Eyes sensitive to light
21. Callous on inner surface of heel
22. Varicose veins
23. Poor dream recall
24. Tend to grind teeth
25. Slow growth (children)
26. Vaginal yeast infections
27. Nails horizontally ridged
28. Nails soft or brittle
29. Dry skin and/or scalp
30. Excessive ear wax
31. Bumpy skin on back of arms and/or thighs
32. Stool that sinks
33. Sensitive to cold, easily chilled
34. Cracks or sores in corner of mouth
35. Elevated Blood Pressure

Circled Answers Indicate Possibility of a Deficiency in the Following Nutrients:

1, 2: Vitamin C, Rutin; **3:** Zinc, Vitamin A; **4, 5, 6, 7, 8:** Zinc; **9:** B_{12} and B Complex; **10:** Magnesium, Potassium; **11:** Iodine; **12:** Pantothenic Acid; **13:** Chromium; **14, 15:** Iron, possibly B_{12}, Copper or B_6; **16, 17, 18, 19:** Calcium, Magnesium, possibly Zinc; **20:** B Vitamins; **21:** Vitamin A; **22:** Fiber, Vit. E, Bioflavonoids, Magnesium; **23:** B_6; **24:** Calcium, Magnesium; **25:** Zinc; **26:** Lactobacillus Acidophilus; **27, 28:**Calcium, Magnesium, Minerals; **29, 30, 31:** Essential Fatty Acids; **32:** Fiber, Water; **33:** Iron; **34:** Riboflavin, B Complex; and **35:** Magnesium, possibly Calcium.

Nutrition Consulting And Health Maximization

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Nutrition Education and Consulting Service
(315) 437-9384

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607-275-9697

NAME:______________________ DATE:______________

Please take any three (3) days in sequence and record everything that you eat or drink. Please include brand names when possible, along with specific types of food and beverages.

Day 1 Breakfast: ______________________

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Mid-AM Snacks:______________________

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Lunch:______________________

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Mid-PM Snacks: ______________________

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Dinner: ______________________

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Snacks:______________________

Drinks: ______________________

Day 2 Breakfast: ______________________

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Mid-AM Snacks:______________________

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Lunch:______________________

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Mid-PM Snacks:______________________

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Dinner: ______________________

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Snacks:______________________

Drinks:______________________

Day 3 Breakfast: ______________________

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Mid-AM Snacks:______________________

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Lunch: ______________________

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Mid-PM Snacks:______________________

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Dinner: ______________________

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Snacks:______________________

Drinks:______________________

PLEASE LIST ANY OF THE FOLLOWING THAT YOU ARE TAKING

SUPPLEMENTS	**MEDICATIONS**
______________	______________
______________	______________
______________	______________