CHEK NUTRITION AND LIFESTYLE QUESTIONNAIRES FOR HLC 1

You Are What You Eat

1. Do you shop less frequently than every four days?

    ___ Yes (1) ___ No (0)

2. Do you eat more packaged (frozen or canned) fruits and vegetables than fresh?

    ___ Yes (3) ___ No (0)

3. Do you eat more cooked vegetables than raw?

    ___ Yes (3) ___ No (0)

4. Do you eat vegetables with less than two meals daily?

    ___ Yes (5) ___ No (0)

5. Do you buy more non-organic vegetables than organic vegetables?

    ___ Yes (5) ___ No (0)

6. Do you use a microwave oven?

    Yes (check option below) ___ No (0)
    ___ 1-2 times per week (2)
    ___ 3-4 times per week (5)
    ___ more than 4 times per week (10)

7. Do you eat quick cook grains such as Rice-aroni, Quaker Oats or Minute rice more often than slow cooked organic whole grains?

    ___ Yes (5) ___ No (0)

8. Do you eat white bread more often than whole grain breads?

    ___ Yes (5) ___ No (0)

9. Do you drink pasteurized/homogenized milk, or eat cheeses frequently?

    Yes (check option below) ___ No (0)
    ___ 1-2 times per week (1)
    ___ 3 times per week (3)
    ___ more than 3 times per week (5)

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10. Do you eat non-organic yogurts that are low fat, presweetened or have fruit added?

Yes (check option below) ___ No (0)
___ 1-2 times per week (1)
___ 3 times per week (3)
___ more than 3 times per week (5)

11. Do you eat typical store bought eggs from cage raised chickens (as apposed to free range, grain fed eggs)?

___ Yes (5) ___ No (0)

12. Do you eat red meat more than once every four days?

___ Yes (3) ___ No (0)

13. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source?

___ Yes (3) ___ No (0)

14. Do you eat canned fish more frequently than fresh fish?

___ Yes (3) ___ No (0)

15. Do you use commercial salad dressings?

Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (3)

16. Do you use Mayonnaise or products containing hydrogenated oils?

Yes (check option below) ___ No (0)
___ once a week (1)
___ twice per week (2)
___ more than 2 times per week (5)

17. Do you eat nuts and/or seeds that are roasted and/or salted?

___ Yes (1) ___ No (0)

18. Do you use white table sugar as a sweetener?

Yes (check option below) ____ No (0)
____ once a week (1)
____ 2-3 times per week (3)
____ more than 3 times per week (5)

19. Do you use artificial sweeteners such as Sweet-n-Low, Equal or Nurtasweet?

Yes (check option below) ____ No (0)
____ once a week (1)
____ 2-3 times per week (5)
____ more than 3 times per week (10)

20. Do you use standard white table salt?

____ Yes (5) ____ No (0)

21. Do you eat TV dinners or other highly processed foods more than three times a week?

____ Yes (5) ____ No (0)

22. Do you eat from fast food restaurants like McDonald's, Arbey's, Wendy's, etc…?

Yes (check option below) ____ No (0)
____ 1-2 times per week (2)
____ 3 times per week (5)
____ more than 3 times per week (10)

23. Do you eat from vending machines?

Yes (check option below) ____ No (0)
____ 1-2 times per week (2)
____ 3 times per week (5)
____ more than 3 times per week (10)

24. Do you drink tap water?

____ Yes (10) ____ No (0)

25. Do you eat some form of store bought dessert, such as ice cream, cookies, donuts, cakes or pies after dinner most nights?

____Yes (check option below) ____ No (0)
____ once a week (1)
____ 2-3 times per week (3)
____ more than 3 times per week (5)

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Stress

1. Do you eat more or less when stressed than when not stressed?

    ____ Yes (10) ____ No (0)

2. Do you worry over job, income or money problems?

    ____ Yes (10) ____ No (0)

3. Are any of your relationships causing you stress?

    ____ Yes (10) ____ No (0)

4. Do you often feel anxious?

    ____ Yes (5) ____ No (0)

5. Do you often feel upset when things go wrong or feel that things go wrong often?

    ____ Yes (5) ____ No (0)

6. Do you lash out at others?

    ____ Yes (5) ____ No (0)

7. Do you feel your sex drive is lower than normal for you?

    ____ Yes (5) ____ No (0)

8. Do you feel stressed due to lack of intimacy in one or more relationships?

    ____ Yes (5) ____ No (0)

9. Have you had reduced contact with friends (feeling antisocial) or an increase in contact because you feel you need to vent your frustrations or stresses to others?

    ____ Yes (3) ____ No (0)

10. Do you feel isolated or suffer from loneliness?

    ____ Yes (3) ____ No (0)

11. Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or a psychological disorder?

___ Yes (15) ___ No (0)

12. Do you lose more than two days of work a year due to illness?

___ Yes (5) ___ No (0)

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Circadian Health

1. Do you live in the same time zone you were born in?

___ Yes (0) ___ No (5)

2. Do you travel across time zones more than once a month?

___ Yes (10) ___ No (0)

3. Do you wake up feeling un-rested and in need of more sleep?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

4. Do you commonly go to bed after 10:30 PM?

___ Yes (10) ___ No (0)

5. Are the times you have bowel movements consistent and predictable on a daily basis?

___ Yes (0) ___ No (5)

6. Do you suffer from reduced memory since moving to a new time zone or since traveling across time zones?

___ Yes (10) ___ No (0)

7. Has your sense of hunger changed from being hungry at breakfast (upon rising), lunch (mid-day) and dinner times (sunset) since moving to a new time zone or traveling across time zones frequently (> 1 x Mo.)?

___ Yes (10) ___ No (0)

8. Do you wake up at night between 1:00 am and 4:00 am and have a hard time falling back to sleep?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

9. Do you tend to have a hard time staying awake in the afternoon after eating lunch?

Yes (check option below) ___ No (0)
___ once a week (1)
___ 3 times per week (5)
___ more than 3 times per week (10)

10. Do you do shift work that requires you to stay up late at night?

___Yes (10) ___ No (0)

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You Are When You Eat

1. Do you frequently skip meals?

   ____ Yes (3) ____ No (0)

2. Do you typically go more than four hours without eating?

   Yes (check option below) ____ No (0)
   ____ 1-2 times per week (1)
   ____ 3 times per week (2)
   ____ more than 3 times per week (3)

3. Do you sometimes skip breakfast?

   Yes (check option below) ____ No (0)
   ____ 2 times per week (1)
   ____ 3 times per week (5)
   ____ more than 3 times per week (10)

4. Do you avoid fats when eating?

   ____ Yes (5) ____ No (0)

5. Do you frequently eat carbohydrates (i.e. breads, bagels, cookies, pasta, fruit, cereals, muffins, crackers, chocolate, or candy) by themselves?

   ____ Yes (5) ____ No (0)

6. Do you get hungry or crave sweets within two hours after eating a meal?

   ____ Yes (5) ____ No (0)

7. Do you use caffeine and/or sugar containing drinks (i.e. coffee, tea, sodas, fruit juices with sucrose, corn syrup or added sugar)?

   Yes (check option below) ____ No (0)
   ____ 1 cup a day (1)
   ____ 2 cups per day (3)
   ____ more than 2 cups per day (5)

8. Have you tried diets to lose weight?

Yes (check option below) ____ No (0)
____ once (1)
____ twice (2)
____ three-five times (5)
____ more than five times (10)

9. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?

____ Yes (3) ____ No (0)

10. Do you eat your largest meal at night?

____ Yes (1) ____ No (0)

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Digestive System Health

1. Do you experience lower abdominal bloating?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 times per week (5)
   ___ more than 3 times per week (10)

2. Do you frequently have loose stools or diarrhea?

   Yes (check option below) ___ No (0)
   ___ once a week (1)
   ___ 3 or more times per week (5)

3. Do you experience constipation or stools that are compact/hard to pass?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 or more times per week (5)

4. Do you find that you often burp/belch after meals?

   ___ Yes (3) ___ No (0)

5. Do you frequently have gas?

   ___ Yes (3) ___ No (0)

6. Do you crave certain foods, such as bread, chocolate, certain fruit, and red meat, if you have not eaten them in a day or two?

   ___ Yes (5) ___ No (0)

7. Do you have a poor appetite and/or feel worse after eating?

   Yes (check option below) ___ No (0)
   ___ 1-2 times per week (3)
   ___ 3 times per week (5)
   ___ more 3 times per week (10)

8. Do you have an excessive appetite and/or sweet cravings?

   ___ Yes (5) ___ No (0)

9. Do you frequently (more than twice a week) experience abdominal pain, cramps or general abdominal discomfort?

___ Yes (20) ___ No (0)

10. Do you have indigestion, heartburn or upset stomach?

Yes (check option below) ___ No (0)
___ 1-2 times per week (3)
___ 3 times per week (5)
___ more than 3 times per week (10)

11. Do you get a headache after eating?

Yes (check option below) ___ No (0)
___ 1-2 times per week (3)
___ more than 3 times per week (5)

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Fungus & Parasites

1. Have you ever been given general anesthesia?

   ___Yes (10) ___No (0)

2. Have you ever taken antibiotics?

   ___Yes (10) ___No (0)

3. Have you been or are you being treated for any condition requiring that you take medical drugs?

   ___Yes (10) ___No (0)

4. In general, are your bowel movements loose, hard or foul smelling?

   ___Yes (10) ___No (0)

5. Would you consider your life to be:

   ___Stress free (0) ___Mildly stressful (5)
   ___Very stressful (10)

6. Do you currently suffer from any digestive disorder or frequently have pain in the region above or below the navel?

   ___Yes (10) ___No (0)

7. Do you have mercury amalgam fillings in your mouth?

   ___Yes (10) ___No (0)

8. Do you have two different kinds of metal in your mouth; i.e., gold and silver or mercury amalgam and gold or silver?

   ___Yes (5) ___No (0)

9. Do you experience itching in the ears, nose or rectum area?

   ___Yes (10) ___No (0)

10. Do you have or have you had dandruff in the past year?

    ___Yes (10) ___No (0)

11. Do you regularly eat or drink products containing sugar, white flour, processed dairy products?

    ___Yes (5) ___No (0)

12. Do you crave sugar, fruit or milk if you don’t have either of these items for more than three days?

    ___Yes (10) ___No (0)

13. Do you find that regardless of how much you eat you get hungry quickly?

    ___Yes (5) ___No (0)

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Detoxification System Health

1. Are your eyes sensitive to bright light?

   ___ Yes (3) ___ No (0)

2. Do you suffer from irritability and have difficulty relaxing?

   ___ Yes (10) ___ No (0)

3. Do you often feel fatigued and sluggish?

   ___ Yes (10) ___ No (0)

4. Do you suffer from frequent headaches?

   Yes (check option below) ___ No (0)
   ___ once a week (1)
   ___ 3 or more per week (5)

5. Do you have dark circles and/or puffiness under eyes?

   Yes (check option below) ___ No (0)
   ___ once a week (3)
   ___ 2-3 times per week (5)
   ___ more than 3 times per week (10)

6. Are you sensitive to perfumes, paint fumes, traffic fumes, detergents or cigarette smoke?

   Yes (check option below) ___ No (0)
   ___ mildly (3)
   ___ moderately (5)
   ___ very (10)

7. Have you been unable to lose cellulite with diet and/or exercise?

   ___ Yes (10) ___ No (0)

8. Are you currently, or have you in the past, been frequently exposed to industrial or agricultural chemicals, such as solvents, cleaning fluids, paint fumes, plant sprays and fertilizers?

   Yes (check option below) ___ No (0)
   ___ brief exposure (3)
   ___ more than once a week (5)
   ___ daily (10)

9. Do you experience mental sluggishness, poor memory or poor concentration?

Yes (check option below) ____ No (0)
____ 1-2 times per week (3)
____ 3 times per week (5)
____ more than 3 times per week (10)

10. Do you suffer from skin reactions such as rashes, itching or burning, for which the cause is unknown?

Yes (check option below) ____ No (0)
____ 1-2 times per month (3)
____ 3 times per month (5)
____ more than 3 times per month (10)

Total Score: ______

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Nutrition and Lifestyle Questionnaires Score Sheet

	You Are What You Eat Zones 1, 2 & 3	Stress Zone 4	Circadian Health Zone 2	You Are When You Eat Zone 3	Digestive System Health Zones 1, 2 & 3	Fungus & Parasites Zones 3 & 4	Detoxification System Health Zones 3 & 4	Total Score
High Priority	130	81	90	50	81	195	88	715
	60	60	70	35	60	120	60	☹
	50	40	50	20	40	60	40	300
Moderate Priority	40	30	40	15	30	50	30	😐
	30	20	30	10	20	40	20	170
Low Priority	15	10	15	5	15	20	10	☺
Score 1								
Score 2								

Name: ______________________ **Date 1:** __________ **Date 2:** __________