Nutrition & Lifestyle Questionnaire

Please complete and return before your first session.

Name: _____

Address: _____ Phone Number: _____

_____

Height: _____ Weight: _____ Usual Body Weight: _____ DOB: _____

Have you experienced any weight changes: ☐ yes / no ☐ Gain / Loss _____ lbs in _____ wks

Current Health Concern(s) you'd like to address with nutrition: mark any that apply

Symptoms: fatigue ☐ depression ☐ migraines ☐ digestion ☐

Managing a chronic condition: diabetes ☐ blood pressure ☐ high cholesterol ☐

Weight loss ☐ Weight gain ☐ Weight management ☐

Prevention of future health problems: _____

Other: _____

Vitamins and Supplements—List dosing and frequency

_____
_____
_____
_____
_____
_____

Medications—List dosing and frequency

_____
_____
_____
_____
_____
_____

What have you eaten in the past 24 hours?

List & describe all meals, snacks, and beverages and approximate amounts.

(Ex: sandwich= 6"sub: white bread, turkey, cheese, spicy mustard, tomato; 1½cups Cheerios & 2%)

_____

_____

_____

_____

_____

_____

_____

_____

_____

Food allergies & intolerances: _____

Food cravings: _____ Foods you avoid/dislike: _____

Meal Patterns:

# of meals per day: _____ # of snacks per day: _____

How often do you eat out each week? _____

What type(s) of restaurants: fast food ☐ sit down ☐ buffet ☐ other ☐

How much water do you drink each day? _____ cups /oz

Do you drink coffee? _____ cups/day ☐ regular or decaf ☐

Do you drink sodas? _____ cans/day ☐ caffeinated or caffeine free ☐

Do you drink alcohol? yes / no

Rate your appetite: _____ (1-poor 5- great)

GI complaints:

		frequency			
Nausea	yes ☐ no ☐	_____	Heartburn	yes ☐ no ☐	_____
Vomiting	yes ☐ no ☐	_____	Flatulence	yes ☐ no ☐	_____
Diarrhea	yes ☐ no ☐	_____	Burping	yes ☐ no ☐	_____
Constipation	yes ☐ no ☐	_____	Bloating	yes ☐ no ☐	_____
Bowel Movement(s)		_____			
		per day or week			

Do you exercise? Yes ☐ No ☐ Sometimes ☐ How often? _____

What is your routine? _____

How well do you sleep? _____ 1- poor 5- great Number of hours each night _____

Life Circumstances

Occupation: _____

How satisfied are you at your current position? _____ 1- not at all 5- very satisfied

Marital Status: ☐ single ☐ married ☐ separated/divorced

Living arrangements/family support system: _____

Cooking arrangements: _____

Who are the important people in your life? _____

Who are you closest to? _____

Who is the most difficult to get along with? _____

Rate the following using this scale: 0= none – 10= high

Stress level: _____ Energy level: _____

What do you do for fun?

_____

_____

_____

What is your spiritual background?

_____

_____

List any current life challenges and transitions:

_____

_____

_____

_____

List the 5 most important things to you:

_____
_____
_____
_____

What are your goals for your health?

Short term goals:

_____
_____
_____
_____

Long term goals:

_____
_____
_____
_____

What do you need out of these nutrition sessions?

_____
_____
_____
_____
_____
_____
_____

How can I best help you reach your goals?

_____
_____
_____
_____
_____
_____
_____
_____