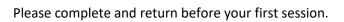
Nutrition & Lifestyle Questionnaire





Name:	_			
Address:				
Height: Weight: Usua	al Body Weight: DOB:			
Have you experienced any weight changes:	yes / no Gain / Loss lbs in wks			
Current Health Concern(s) you'd like to addre	ess with nutrition: mark any that apply			
Symptoms: fatigue depression mi	graines digestion			
Managing a chronic condition: diabetes	blood pressure high cholesterol			
Weight loss Weight gain Weight ma	anagement			
Prevention of future health problems:				
Other:				
Vitamins and Supplements—List dosing and fre	equency			
Medications—List dosing and frequency				

villat liave you eate			<u>.</u>				
List & describe all mo			•	• •			
(Ex: sandwich= 6"sul	o: white	e bread	, turkey, che	eese, spicy musta	rd, tomato;	1½cups	Cheerios & 2%
Food allergies & into	lerance	es:					
Food cravings:			Fo	oods you avoid/di	slike:		
				•			
Meal Patterns:							
# of meals per day: _		_	#	of snacks per day	:		
How often do you ea	at out e	ach we	ek?				
What type(s) of resta	aurants	: fast f	ood si	t down buffe	et o	ther	
How much water do	you dr	ink eac	h day?	cups /oz			
Do you drink coffee?	·	cups	/day	regular or d	ecaf		
Do you drink sodas?	·	cans	/day ca	affeinated or caffe	ine free		
Do you drink alcohol	? yes /	no '					
Rate your appetite: _			(1-poor	5- great)			
GI complaints:			frequency	,			
Nausea	yes	no	пециенсу	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 o	lay or week				

Do you exercise?	Yes	No	Sometimes	How often?
What is your routine	?			
How well do you slee	ep?	1	- poor 5- great	Number of hours each night
<u>Life Circumstances</u> Occupation:				
				1- not at all 5- very satisfied
Marital Status:	single		married	separated/divorced
Who are the importa	nt peop	ole in y	our life?	
Who are you closest	to?			
Who is the most diffi	cult to	get alo	ng with?	
Rate the following us Stress level:	_			_
What do you do for f				
What is your spiritua				
List any current life c	halleng 	es and	transitions:	

List the 5 most important things to you:	
What are your goals for your health?	
Short term goals:	
Long term goals:	
Long term goals.	
What do you need out of these nutrition sessions?	
How can I best help you reach your goals?	
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