Nutritional Questionnaire

This information is Confidential

Name_____ Birth Date_____ Date_____

Address_____ City_____ State_____ Zip_____

Home Phone _____ Cell Phone _____ M F (please circle)

Height _____ Current Weight _____ Usual Weight _____ Goal Weight _____

Email address _____ Impedance _____ (We will measure this)

Are you interested in a Complimentary Nutritional Consultation? _____

Are you interested in learning more about a nutrition-counseling program? _____

Have you ever participated in a nutrition counseling program that is based on real food and long term lifestyle changes, not a commercialized weight loss program or personal trainer? _____

What Nutritional Programs or Diets have you tried in the past, if any? _____

What are your most Important Reason(s) for considering nutritional counseling? (start with most important)

_____

_____

PLEASE RATE HOW IMPORTANT THESE FACTORS ARE TO YOU. ANSWER **1 to 10.**
1 = LEAST IMPORTANT **5 = MEDIUM IMPORTANT** **10 = VERY IMPORTANT**

Is nutrition counseling for **cancer, heart disease, and disease prevention** important? _____
Is nutrition counseling for **weight management (reduce body fat & increase muscle**) important? _____
Is nutrition counseling for **weight gain (lean mass increase**) important? _____
Is nutrition counseling to **have more energy** and better workouts? _____

How many **pounds** would you like to **loss or gain** (circle one) in each **week or month (circle one)**? _____**lbs**

What is a realistic Exercise program for you to complete Weekly?
LIST AT LEAST ONE PRIMARY EXERCISE (S):

1. _____ MINUTES: _____ Days/Wk _____

2. _____ MINUTES: _____ Days/Wk _____

3._____ MINUTES: _____ Days/Wk _____

MEDICAL HISTORY **Do you now have, or have you had any of these conditions in the past:**

	NO	YES
Heart problems, recurring chest pain, heart murmur, or stroke		
Hypertension or take medicine for same		
Diabetes Mellitus		
Asthma, breathing or lung problems		
Cancer (other than skin)		
Seizures, seizure medication, neurological problems or severe dizziness		
Gallbladder disease or intestinal problems		
Back problem, joint or muscle disorder still affecting you		
Recent surgery (last 12 months)		
Hernia or any condition that may be aggravated by lifting weights		
Physician's advice not to exercise		
WOMEN ONLY: Are you pregnant, lactating or anticipating becoming pregnant?		

If your answer is YES to any question above, please give *brief* explanation: _____

_____

	NO	YES
History of total Cholesterol greater than 200 mg/dl		
Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55		
Do you currently smoke cigarettes?		
Have you ever smoked cigarettes?		
Do you take vitamins or supplements?		
Are you allergic to soy?		
Are you allergic to lactose / dairy products?		
Are you allergic to gluten?		
Do you have any other dietary restrictions?		
Are you taking any medications?		

If so, please list your medications: _____

Primary Physician's Name _____ Phone Number _____

May we send a summary of your results to your physician? _____

Emergency Contact, please provide the name of a person we can contact in case of an emergency:

_____ Relationship _____

Phone Number _____

Typical Daily Food Log

(1 day- Minimum)

Please include Meals, Snacks, and Beverages. Estimate Portion Sizes.

TIME	FOOD EATEN	SERVING SIZE	HOME/RESTAURANT

Disclaimer

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide will be used to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program or taking any supplements. I take full responsibility for my participation in any of these programs and for any injuries or illness that may result from my participation in any of their programs.

_____ _____

Signature Date

_____ _____

Witness Date