CLIENT NUTRITION QUESTIONNAIRE

Name: _____ *Date:* _____

Health Information

Do you have any diagnosed medical conditions? If yes, please list them.

_____

Are you currently taking any medications or supplements?

_____

Do you have any allergies or intolerances to foods? If yes, please specify.

_____

Eating Habits

Let's dive a little deeper into your eating patterns. This will help better understand your nutrition habits!

What is the average number of meals eaten per day?

_____

What time of the day do you usually get the most hungry?

_____

When do you first get hungry?

_____

Are you on a specific diet or would you like to be? examples: vegan, vegetarian, pescatarian?

_____

On your cycle how does this change (Women)?

Talk about your snacking habits, you have to be honest here! i.e., how often, time of day, foods you choose?

What meals and how frequently do you eat at restaurants or get take out each week?

What kinds of restaurants do you usually eat at (i.e., fast food, sit down, etc.)?

How often do you consume alcohol? If so, what do you drink?

What are your favorite foods that you cannot live without!

What are foods that you despise (that you can definitely live without)!

How willing and able to cook meals?

Goals and preferences

I want to hear about your nutritional goals. What would you like to achieve? What would you like to see and feel about your relationship with food

What are your goals seeking nutritional advice? (weight loss, muscle building, being healthy)
