

## Intake Questionnaire – Nutrition

Name: \_\_\_\_\_

Age:            Weight:            Gender:            Allergies:

Current Medications:

Current Medical Conditions:

What are your health goals? What would you like to work on/learn about today?

History of Eating Disorder:

Caffeine Intake Per Day:

Alcohol Intake Per Day (or Week):

Exercise Per Week – Describe type and duration:

Usual Sleep Pattern: do you wake often, have difficulty getting and/or staying asleep?

Are you a vegetarian? If so, to what degree?

Where and how often do you eat out?

Do you eat in the car/on the go?

Do you enjoy cooking?

Hobbies:

During stressful events (good or bad) do you eat or do you starve? If you eat, what do you eat?

Do you often have cravings for certain foods? If so, what foods and when do you crave them?

Has your weight changed much in the last year? If so, how much?

Describe your energy throughout the day?

Do you have any gastro/intestinal disorders, such as, diarrhea, constipation, abdominal pain?

Do you have a bowel movement every day?

## **Intake Questionnaire – Nutrition**

Describe typical meals and snacks for you including *when* you eat them. Also indicate how you feel (energy level, shakiness, etc) before and after you eat:

**Breakfast**

**Lunch**

**Dinner**

**Snacks**