NUTRITION CONSULTATION FORM

DATE: _____

YOUR CONFIDENTIAL INFORMATION

NAME: _____

PHONE: _____

EMAIL: _____

PREFERRED METHOD OF CONTACT: PHONE OR EMAIL

AGE: _____

DATE OF BIRTH: _____

HEIGHT: (FEET)_____ (INCHES)_____

CURRENT BODY WEIGHT:_____

DESIRED BODY WEIGHT: _____

LOWEST BODY WEIGHT:_____YEAR: _____

HIGHEST BODY WEIGHT:_____YEAR:_____

EXTRA CURRICULAR ACTIVITIES / SPORTS: _____

_____

PHYSICIAN: _____

NUTRITION AND FITNESS GOALS:

WHAT ARE YOUR NUTRITION AND FITNESS GOALS?

1. _____
2. _____
3. _____
4. _____
5. _____

WHAT HAVE YOU TRIED IN THE PAST TO ACHIEVE YOUR NUTRITION AND FITNESS GOALS? THIS INCLUDES ANY DIET OR EXERCISE PROGRAM, SUPPLEMENT USE, BOOKS, ETC...

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICAL HISTORY AND MEDICATIONS:

PLEASE LIST ANY RELEVANT PAST MEDICAL HISTORY AND CURRENT MEDICATIONS:
I.E. FOOD ALLERGIES/INTOLERANCES, HIGH CHOLESTEROL, DIABETES, HEART DISEASE, ADHD, HYPO/HYPERTHYROIDISM, RECENT SURGERIES, BOWL DISEASE, DEPRESSION, EATING DISORDERS, RECENT ATHLETIC INJURIES, ANEMIA, ETC...

_____

_____

HAVE YOU EVER BEEN DIAGNOSED WITH AN EATING DISORDER? YES OR NO
HAVE YOU EVER STRUGGLED WITH EATING DISORDERED BEHAVIORS? I.E RESTRICTING FOOD, DIET PILLS, LAXATIVES, BINGING AND OR VOMITING... YES OR NO IF YES, PLEASE SPECIFY BEHAVIORS.

_____

_____

FEMALES ONLY:

AT WHAT AGE DID YOU GET YOUR FIRST PERIOD?

DO YOU GET REGULAR PERIODS? YES OR NO

WHEN WAS YOUR LAST MENSTRUAL PERIOD? _____ HOW LONG DID IT LAST? _____

DO YOU TAKE ANY VITAMIN / MINERAL SUPPLEMENTS? YES OR NO

IF YES, PLEASE LIST BELOW:

_____

_____

DO YOU TAKE ANY TYPE OF NUTRITIONAL SUPPLEMENTS (I.E. PROTEIN SHAKES, POWDERS, ENERGY DRINKS, ETC.) PLEASE BE VERY SPECIFIC AND IF NECESSARY ATTACH A PICTURE OF THE LABEL/INGREDIENTS.

_____

_____

ARE THERE ANY FOODS THAT YOU AVOID? YES OR NO

IF YES, PLEASE LIST BELOW:

ARE THERE ANY FOODS THAT YOU AVOID? YES OR NO

IF YES, PLEASE LIST BELOW:

ARE YOU A VEGETARIAN? YES OR NO

IF YES, PLEASE CIRCLE WHICH FOODS YOU DO NOT EAT: CHICKEN FISH DAIRY EGGS RED MEAT

ON AVERAGE, HOW MANY DAYS A WEEK DO YOU CONSUME ALCOHOLIC BEVERAGES? _____

ON AVERAGE, HOW MANY ALCOHOLIC DRINKS DO YOU CONSUME AT ONE TIME? _____

WHAT TYPES OF ALCOHOL DO YOU CONSUME? BEER WINE LIQUOR OTHER

ON AVERAGE, HOW MANY CAFFEINATED BEVERAGES DO YOU CONSUME PER DAY? _____

WHAT TYPES OF CAFFEINATED BEVERAGES DO YOU CONSUME? _____
I.E. ENERGY DRINKS, COFFEE, TEA, SODA, ETC.

DO YOU SMOKE (TOBACCO PRODUCTS)? YES OR NO

IF YES, HOW MANY CIGARETTES PER DAY? _____

ON AVERAGE, ABOUT HOW MANY HOURS DO YOU SLEEP: WEEKNIGHTS _____ WEEKENDS _____

ARE YOU STRESSED? YES OR NO

IF YES, HOW STRESSED ARE YOU? PLEASE CIRCLE 1 2 3 4 5 NOT AT ALL, A LITTLE, MODERATE, VERY, EXTREMELY

HOW DO YOU MANAGE YOUR STRESS?

HAVE YOU SEEN A COUNSELOR / THERAPIST IN THE PAST, OR ARE YOU WORKING WITH SOMEONE PRESENTLY?

EXERCISE:

ARE YOU CURRENTLY ON AN EXERCISE PROGRAM? YES OR NO

IF SO, WHAT SPECIFICALLY ARE YOU DOING EACH DAY?

SUNDAY: _____

MONDAY: _____

TUESDAY: _____

WEDNESDAY: _____

THURSDAY _____

FRIDAY: _____

SATURDAY: _____

ARE YOU CURRENTLY WORKING WITH A TRAINER OR COACH? YES OR NO

IF YES, WHO AND WHEN?

_____

_____

HAVE YOU EVER PLAYED A SPORT? YES OR NO

IF YES, WHICH SPORT(S), WHEN, AND HOW LONG?

_____

_____

NUTRITION LOG:

PLEASE LIST OUT WHAT A TYPICAL DAY OF EATING LOOKS LIKE FOR YOU.

PLEASE BE VERY SPECIFIC, INCLUDING TIMES, PORTION SIZES, AND BRANDS.

I.E. 1 CUP OF TROPICANA ORANGE JUICE, 6 OUNCES NON FAT DANNON YOGURT, ETC...

BREAKFAST:

TIME: _____

ITEM(S): _____

_____

_____

MORNING SNACK:

TIME: _____

ITEM(S): _____

_____

_____

LUNCH:

TIME: _____

ITEM(S): _____

AFTERNOON SNACK:

TIME: _____

ITEM(S): _____

DINNER:

TIME: _____

ITEM(S): _____

SNACK/DESSERT:

TIME: _____

ITEM(S): _____

EXERCISE:

PLEASE LIST ANY ADDITIONAL INFORMATION YOU FEEL WOULD BE HELPFUL FOR ME TO KNOW.