Firstfruits Nutrition
Nutrition Counseling & Health Coaching

Lifestyle and Health History Questionnaire

Name: _____ Date: _____ Date of birth: _____

Medical Information

1. How would you describe your present state of health?
☐Very well ☐ Healthy ☐ Unhealthy ☐ Unwell Other:
_____

2. List current medications, how often you take them, and dosages (include prescriptions and over-the-counter medications).
_____
_____
_____

3. Do you take all of your medications as they have been prescribed by your healthcare provider?
☐Yes ☐No
If not, please share why (e.g., cost, side effects, or feeling as though they are unnecessary).
_____
_____

4. Do you take any vitamin, mineral, or herbal supplements? ☐Yes ☐No
If yes, list type and amount per day:
_____

5. When was the last time you visited your physician?
_____

6. Have you ever had your cholesterol checked? ☐Yes ☐No
Date of test: _____ What were the results? _____
Total cholesterol: _____ High-density lipoprotein (HDL): _____
Low-density lipoprotein (LDL): _____ Triglycerides: _____

7. Have you ever had your blood sugar checked? ☐Yes ☐No
What were the results?
_____

8. Please check any that apply to you and list any important information about your condition:

☐Allergies (Specify: _____) ☐Amenorrhea ☐Anemia
☐Anxiety ☐Arthritis ☐Asthma
☐Celiac disease ☐Chronic sinus condition ☐Constipation
☐Crohn's disease ☐Depression ☐Diabetes
☐Diarrhea ☐Disordered eating ☐Gastroesophageal reflux
☐High blood pressure ☐Hypoglycemia ☐Hypo/hyperthyroidism
☐Insomnia ☐Intestinal problems ☐Irritability
☐Irritable bowel syndrome ☐Menopausal symptoms ☐Osteoporosis
☐Premenstrual syndrome ☐Polycystic ovary syndrome ☐Pregnant
☐Skin problems ☐Ulcer

Major surgeries: _____

Past injuries: _____

Describe any other health conditions that you have:

_____

_____

Family History

1. Has anyone in your immediate family been diagnosed with the following?

☐Heart disease If yes, what is the relation? _____ Age of diagnosis: _____

☐High cholesterol If yes, what is the relation? _____ Age of diagnosis: _____
☐High blood pressure If yes, what is the relation? _____ Age of diagnosis: _____
☐Cancer If yes, what is the relation? _____ Age of diagnosis: _____
☐Diabetes If yes, what is the relation? _____ Age of diagnosis: _____
☐Osteoporosis If yes, what is the relation? _____ Age of diagnosis: _____

Nutrition

1. What are your dietary goals?

_____

2. Have you ever followed a modified diet? ☐Yes ☐No
If yes, describe:

_____

3. Are you currently following a specialized eating plan (e.g., low-sodium or low-fat)? ☐Yes ☐No
If yes, what type of eating plan?

_____

4. Why did you choose this eating plan?

_____

Was the eating plan prescribed by a physician? ☐Yes ☐No

How long have you been on the eating plan?

_____

5. Have you ever met with a registered dietitian or attended diabetes education classes? ☐Yes ☐No
If yes, describe:

_____

6. What do you consider to be the major issues with your nutritional choices or eating plan (e.g., eating late at night, snacking on high-fat foods, skipping meals, or lack of variety)?

_____
_____
_____

7. How many glasses of water do you drink per day? _____ 8-ounce glasses

8. What do you drink other than water? List what and how much per day.

_____

9. Do you have any food allergies or intolerances? ☐Yes ☐No
If yes, what?

_____

10. Who shops for and prepares your food? ☐Self ☐Spouse ☐Parent ☐ Minimal preparation

11. How often do you dine out? _____ times per week

12. Please specify the type of restaurants for each meal:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

13. Do you crave any foods? ☐Yes ☐No
If yes, please specify:

_____

Substance-Related Habits

1. Do you drink alcohol? ☐Yes ☐No
If yes, how often? _____ times per week Average amount? _____

2. Do you drink caffeinated beverages? ☐Yes☐No If yes, average number per day:_____
3. Do you use tobacco? ☐Yes ☐No
If yes, how much (cigarettes, cigars, or chewing tobacco per day)?

_____

Physical Activity

1. Do you currently participate in any structured physical activity? ☐Yes ☐No
If so, please describe:
_____ minutes of cardiorespiratory activity, _____ times per week
_____ muscular-training sessions per week
_____ flexibility-training sessions per week
_____ minutes of sports or recreational activities per week
List sports or activities you participate in:
_____

2. Do you engage in any other forms of regular physical activity? ☐Yes ☐No
If yes, describe:
_____

3. Have you ever experienced any injuries that may limit your physical activity? ☐Yes ☐No
If yes, describe:
_____

4. Do you have any physical-activity restrictions?
If so, please list:
_____
_____
_____

5. What are your honest feelings about exercise/physical activity?
_____
_____
_____

6. What are some of your favorite physical activities?
_____
_____
_____

Occupational

1. Do you work? ☐Yes ☐No
If yes, what is your occupation?
_____
If you work, what is your work schedule?
_____

2. Describe your activity level during the work day:

_____

Sleep and Stress

1. How many hours of sleep do you get at night? _____

2. Rate your average stress level from 1 (no stress) to 10 (constant stress) _____

3. What is most stressful to you?

_____

4. How is your appetite affected by stress? ☐Increased ☐Not affected ☐ Decreased

Weight History

1. What is your height? _____

2. What is your present weight? _____☐Don't know

3. What would you like to do with your weight?
☐Lose weight ☐Gain weight ☐Maintain weight

4. What was your lowest weight within the past 5 years? _____

5. What was your highest weight within the past 5 years? _____

6. What do you consider to be your ideal weight (the sustainable weight at which you feel best)?
_____☐Don't know

7. What are your current waist and hip circumferences? _____Waist _____ Hip ☐Don't know

8. What is your current body composition? _____% body fat ☐Don't know

Goals

1. On a scale of 1 to 10, how likely are you to adopt a healthier lifestyle (1 = very unlikely; 10 = very likely)? _____

2. Do you have any specific goals for improving your health? ☐Yes ☐No
If yes, please list them in order of importance.

_____

_____

3. Do you have a weight-loss goal? ☐Yes ☐No
If yes, what is it?

_____

4. Why do you want to lose weight?

_____

_____