COUNSELLING FORM

Please fill out this questionnaire prior to your Consultation. This information will contribute to the development of a program based on your needs and current lifestyle habits. Please feel free to include any additional information that you feel might be relevant to your current situation.

Name: _____

Goals for this consultation: _____

_____

Gender :   ○ Male   ○ Female

Marital Status :   ○ Married   ○ Unmarried

Job Profile : _____

Age: _____

Date of Birth: _____

Height: _____

Current Weight: _____

Blood Group:_____

Have you ever had your body composition measured?   ○ Yes   ○ No

If yes, how was it measured and what were your results?

_____

Your Sleeping Hours : Sleep at _____**Wakeup** _____

Do you have any food allergies or intolerances?   ○ Yes   ○ No

If yes, please list_____

Do you take any vitamin, mineral or herbal supplements, medication ?   ○ Yes   ○ No

If yes, please list all supplements_____

Your Physical activity level. Check those that may apply.

○ Sedentary lifestyle (little or No Exercise, desk job)

○ Moderately Active (Walk, Exercise 3-4 days weekly)

○ Very Active (Walk, Exercise daily)

Your family medical history (IF ANY)

_____

Your medical history, (IF ANY) _____

_____

Your food specifications . Check those that may apply.

○ Vegetarian

○ Non – Vegetarian

○ Vegan (No Egg, Milk, Meat)

○ Lacto – Ova Vegetarian (Egg included)

Your Food likes & Dislikes _____

_____

Do you Smoke ?   ○ Yes   ○ No

If yes , how frequently _____

Do you consume Alcohol ?   ○ Yes   ○ No

If yes , how frequently _____

Do you get routine health checkup done ?   ○ Yes   ○ No

If yes , how frequently _____

Enclosed Blood reports (Not older than 3 Months)   ○ Yes   ○ No

Pregnant   ○ Yes   ○ No

Lactating   ○ Yes   ○ No

Your Menstrual Cycle   ○ Normal   ○ Delayed

If Delayed , mention your Last menstrual cycle period date _____

Please provide your daily food Routine with your Meal timings.

Early Morning - Time

_____

_____

Breakfast - Time

_____

_____

Lunch - Time

_____

_____

Evening - Time

_____

_____

Dinner - Time

_____

_____

Post Dinner   - Time

_____

_____

I declare all information given by me is correct .I am consulting a nutritionist & dietician for my better health and will follow the plan as guided by them. They are my food & health advisor not doctors.

Sign _____