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Nutritional Consultation Health History Questionnaire

Last Name: _____ First Name: _____

Date of Birth: _____Age ___ Home Phone (____)_____Cell (____)_____

Height _____ Weight ____ E-mail address _____

Address: _____

City: _____State: _____ Zip: _____

Contact person in case of emergency:

Last name _____ First Name: _____

Relationship: _____ Phone: _____

Medical Information:
Name of Physician: _____ Phone _____

List any serious/Chronic illnesses of which you are aware:
_____
_____
_____
_____
_____
Are you currently taking medications/supplements? Yes No

If yes, please list: _____
_____
_____
_____
_____

Indicate any injuries (past/present) or limitations that may affect participation in an exercise program:
_____
_____
_____
_____

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Personal/Family History
Occurrence in immediate family, self, mother/father, sister/brother.

	Yes	No	You or Relative (if relative-please be specific)
High Blood pressure			
Heart Attack/Stroke			
Chest Pain			
Diabetes			
Elevated Cholesterol			
Asthma			
Obesity			

Are you a current smoker or have you recently quit smoking within the past 6 months? _____

What are your personal health and fitness goals with your customized nutritional consultation package?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

How committed are you to doing your part to reach your goals?
___Strongly Committed _____Somewhat Committed _____ Not Sure

(Optional) Please provide any additional comments concerning your commitment level.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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When completing this form, please keep in mind that these questions are based on your current eating habits, your current life-style, and your current activity level and are not to be thought of as your ideal or soon-to-be eating habits, life-style and activity level. To this end, for the purposes of this questionnaire, current means consistent for the past 2 months.

1. Do you regularly eat breakfast Yes No

2. How many meals do you eat daily? _____ At what times? _____

3. Do you regularly eat past the point of no longer being hungry? Yes No

4. At what time of day do you eat your largest meal? _____

5. Do you snack between meals? Yes No

6. If yes, list the types of snacks you eat between meals.
   _____
   _____
   _____
   _____
   _____

7. Do you have a snack before you go to bed? Yes No

8. If yes, list the types of snacks you have before going to bed.
   _____
   _____
   _____
   _____

9. List any and all vegetables that you currently eat and/or that you like?
   _____
   _____
   _____
   _____

10. How many hours of sleep do you average per night? _____

11. Do you eat junk food? Yes No

12. If yes, list the junk foods you eat most often:
    _____
    _____
    _____

13. How often do you eat fast food? _____x's per day OR _____x's per week

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14. List any fried foods you eat.
    _____
    _____
    _____

15. How often do you eat fried foods? _____x's per day OR x's per week

16. Who does the grocery shopping in your home? _____

17. How often do you pack your lunch? _____

18. How often do you eat home-cooked meals? _____

19. How often do you eat pre-package meals? For example frozen meals, store-bought pre-made salads, store bought sandwiches etc. _____x's per day OR _____x's per week.

20. List any foods in which you are allergic.
    _____
    _____

21. List any "not-so-good for you foods" you are unwilling to give up.
_____
_____
_____
_____

22. List any foods you do not and will not eat.
_____
_____
_____
_____
_____

23. Are you willing to try new foods if they will benefit you in your healthy endeavors? Yes/No

24. Describe your ***typical*** eating day in terms of what time you wake up, what time you eat your first meal, snacks, second meal, snacks, last meal, snack etc.
    _____
    _____
    _____
    _____
    _____

25. Describe your typical breakfast, lunch, and dinner meals.
    _____
    _____
    _____
    _____
    _____

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26. Please check all that apply: _____I eat when I am stressed. _____I eat when I am sad. _____I eat when I am bored. ____I eat when I'm not hungry. _____I eat to celebrate

27. List any "comfort" foods that temporarily make you feel good. _____
_____
_____

28. Do you become sleepy or sluggish after consuming meals? Always Sometimes Rarely

29. List any "weight loss" programs you have tried or been a part of in the past 10 years. Also list your weight loss results with those programs, including any applicable rebound weight gain).
_____
_____
_____
_____
_____

30. What type of customized meal plan works best for your lifestyle?
___Tightly structured (specific foods with very little deviation).
___Medium structure (specific foods with decent amount of deviation)
___Loosely structured (specific food groups with wide latitude of deviation)
Please keep in mind, your customized meal plan consists of the healthiest food choices (based on your needs) regardless of the structure you choose.

31. Are you currently involved in a regular exercise program? ___yes ___no
    - If yes, please describe in details your current exercise program.
        - (type of exercise, # of times per week, minutes per day etc.)

32. Do you regular lift weights or participate in strength training? __yes ____no
    - If yes, please indicate the number of times per week. _____ #times/week

33. Please circle your current physical activity level:
    - Sedentary lightly active moderately active highly active

34. Please circle how you would characterize your life-style:
    - Highly Stressful moderately stressful low in stress

35. Please describe your knowledge of exercise and fitness:
    - Very knowledgeable knowledgeable no knowledge

36. Briefly describe your involvement in physical activity in the past:
    - 6 months: _____
    - 12 months: _____
    - 5 years: _____

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- Lifetime: _____

37. Do you start exercise programs but then find yourself unable to stick with them?
___yes ___no

38. How much time are you willing to devote to any exercise program?
    - Minutes/day _____ Days/Week_____

39. Can you exercise during your working day? ___yes ____no

40. Would an exercise program interfere with your job? ___yes ___no

41. If you are a student, can you exercise during your school day? ___yes ___no

42. What types of exercise interest you? Check all that apply.

    - ___walking ___jogging __running __weight training __swimming
    - ___stretching ___cycling (outdoors) __ stationary cycling __ kickboxing
    - ___aerobics class __interval training "HIIT" __Boot Camp
      ___Other_____

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