NUTRITION QUESTIONNAIRE

CLIENT NAME::		**DOB:**		**MALE/FEMALE:**	
DATE:		**WEIGHT (KG):**		**HEIGHT (CM):**	
CONTACT DETAILS:	PH:	EMAIL:			
OCCUPATION:					

GENERAL DIETARY HABITS:

1)	**How many glasses of water do you drink per day?**
2)	**Do you drink alcohol? (yes/no)** *(If yes, how many standard drinks would you have in an average week?)*
3)	**Do you ever skip breakfast, lunch or dinner?** *(If so, please provide details below)*
4)	**Do you drink tea or coffee regularly (yes/no)** *(If yes, how many standard cups of tea or coffee would you have per day?)*

5)	**Do you feel as though you have a 'bad' relationship with food** *(If yes, please provide more details below)*

6)	**Do you smoke or have you previously smoked in the past? (yes/no)** *(If yes, provide details for how often you smoke per day. If you no longer smoke, please provide details on when you stopped)*

7)	**Please list any foods below that you particularly like or dislike.**

8)	**Beside allergies or intolerances, do you have any other dietary restrictions?**

9)	**Do you regularly suffer from any cravings?** *Please discuss in detail including craving frequency, food type and if you are aware of any triggers.*

10)	**Are you currently taking any supplements and/or vitamins? Please list these below and provide dosage details.** *(This question is not referring to medications)*

11)	**How often do you have a bowel movement?** *Please tick the most appropriate box below:*

More than 3 times per day		*1-2 times per day*		*2-3 times per day*	
Once every 2-3 days		*A few times per week*		*Once per week*	

	Have you tried any diets or approach(s) in the past in an attempt to change any dietary habits? (yes/no) *If you answered yes for the above question, please describe below:* – *The methods/types of diet have you tried in the past to change your dietary habits.* – *Why you stopped/discontinued the approach(s)?*

12)	
	On a scale of 1 – 10 (10 being the hardest) how difficult did you find the process of the above approach(s)? (please circle)

1	2	3	4	5	6	7	8	9	10

HEALTH GOALS AND MOTIVES:

13) List your top three priorities in life.

14) What are your current health-related goals?
Please also provide details on how long you think it will take to achieve these goals?

15) In what ways do you think your weight management is negatively impacting on your health or lifestyle (if any)?

16) What is your greatest motivation to become healthy?

17) What do you think you would have to change in your diet or lifestyle to enable you to achieve your goals?

18) What do you think are the biggest challenges to achieving your goals?
(Please tick the boxes and explain where possible).

Knowledge		*Willpower*		*Time*	
Support		*Finances*		*Boredom*	
Energy		*Stress*		*Health Issues*	

19) How confident are you that you can reach your health goals?

20) How could I help you increase your confidence?
(e.g. recipe ideas, handy tips, regular appointments etc)

21) Are you looking for a full meal plan or would you prefer to adjust your current lifestyle with some additions?
(If neither, please advise what are you hoping to achieve in today's session?)

OTHER LIFESTYLE FACTORS:

22)	**Who do you live with (i.e. family or friends)?**
23)	**Who does most of the cooking at home?**
24)	**Are your friends and family supportive of your lifestyle goals?**
25)	**How frequently do you consume takeaway or eat out at restaurants? Please provide details.**
26)	**Roughly, how much do you budget for groceries each week?**
27)	**Do you have access to all basic cooking equipment such as an oven, stove, microwave and blender?**
28)	**How much sleep are you getting?** *(Please provide details on hours of sleep each night as well as details if its broken/unbroken sleep)*