**Nutrition Consulting Questionnaire**

Name: Date:

Email:

Current Weight: (pounds) Height: Age:

Rate your stress levels, 1 as the lowest, 10 as the highest. 1 2 3 4 5 6 7 8 9 10

What are your health goals? (EX: gain muscle, lose wight, feel better, improve performance)

What are you willing to do to reach that goal right now?

What won’t you do for that goal?

What have you tried in the past to change your habits, health, eating, or body composition?

Why did/didn’t those changes work for you?

How would you currently rate your overall nutrition/eating habits? Why do you give this rating?

(1=Poor, 10=Perfect) 1 2 3 4 5 6 7 8 9 10

What do you expect to get out of this nutrition consultation?

What are the biggest challenges that prevent you from improving your health and eating habits?

What indicators would tell you that your reaching your goal? (EX: clothes feeling loose, weight on scale, body composition measurements, improved athletic performance)

How many hours of sleep do you get a night on average? 4 5 6 7 8 9 10 11 12

Are you currently taking any supplements? Yes No If yes, what are you taking?

Do you follow a specific diet? (EX: vegetarian, vegan, high protein, keto, paleo, etc..)

Yes No If yes, what diet do you follow?

List food allergies/intolerances if any:

Do you currently work? Yes No

Does work, practice or classes interfere with your feeding times? Yes No

How do you prefer me to contact you? (Leave number below for preferred contact if phone or text is circled)

Email Text Phone In-person meetings