

# **Introductory Nutrition Form**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_

Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Section 1: Anthropometric Data**

1. Height: \_\_\_\_\_\_\_\_\_\_ cm/inches

2. Weight: \_\_\_\_\_\_\_\_\_\_ kg/lbs

3. BMI: \_\_\_\_\_\_\_\_\_\_

4. Waist Circumference:\_\_\_\_\_\_\_\_\_\_ cm/inches

5. Hip Circumference: \_\_\_\_\_\_\_\_\_\_ cm/inches

6. Body Fat Percentage: \_\_\_\_\_\_\_\_\_\_ %

7. Muscle Mass:\_\_\_\_\_\_\_\_\_\_ kg/lbs

8. Blood Pressure: Super Good Blood Pressure:

9. Resting Heart Rate:\_\_\_\_\_\_\_\_\_\_ bpm

Last Time he got blood work:

**Section 2: Health History**

1. Do you have any chronic conditions?

 (e.g., diabetes, hypertension, cardiovascular disease, etc.)

 - Yes / No

 - If yes, please specify: No

2. Have you had any recent surgeries or injuries?

 - Yes / No

 - If yes, please specify:

3. Are you currently taking any medications or supplements?

 - Yes / No

 - If yes, please list:

4. Do you have any food allergies or intolerances?

 - Yes / No

 - If yes, please list:

5. Family history of health conditions:

 (e.g., diabetes, heart disease, obesity, etc.)

 - Yes / No

 - If yes, please specify:

6. Are you currently pregnant or breastfeeding?

 - Yes /No

7. Do you smoke?

 - Yes / No

 - If yes, how many cigarettes per day? \_\_\_\_\_\_\_\_\_\_

8. Do you consume alcohol?

 - Yes / No

 - If yes, how often and how much?

**Section 3: Nutrition and Lifestyle**

1. Describe your typical daily diet:

 - Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 - Lunch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 - Dinner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 - Snacks: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 - Beverages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. How often do you eat out or order takeout?

 - Rarely / Occasionally / Often / Daily-

3. Do you follow any specific diet or eating plan?

 - Yes / No

 - If yes, please specify (e.g., vegan, keto, intermittent fasting):

4. How many meals do you eat per day?

 - 1 / 2 / 3 / 4 / More-

5. Do you have any food cravings?

 - Yes / No

 - If yes, please specify:

6. Do you experience any digestive issues?

 (e.g., bloating, gas, constipation)

 - Yes / No

 - If yes, please specify:

7. How often do you exercise?

 - Rarely / Occasionally / Regularly

 - Type of exercise:

 - Duration per session:

8. How would you describe your stress levels?

 - Low / Moderate / High

9. How many hours of sleep do you get per night?

 - Less than 5 / 5-6 / 7-8 / More than 8-

10. What are your nutrition and health goals?

 - Weight loss / Muscle gain / Improved energy / Better digestion / General wellness / Other:

Questions/Concerns: