

Nutrition Questionnaire

Date: _____

Name: _____ Birth date: _____ Age: _____

Sex: _____

Address: _____

Phone number: _____

Weight: _____ Height: _____

Lowest Adult Weight: _____ Highest Adult Weight: _____

Nutrition Goals: _____

Exercise Routine: # Days week _____ Duration: _____

Current Medical Conditions: _____

Current Medications: _____

Current Supplements/Vitamins _____

Previous Diet Programs: _____

Where are most of your meals prepared? _____

Number of fast food meals a week: _____

Number of restaurant meals a week: _____

Food Allergies/Intolerances: _____

Number of Alcoholic Beverages Consumed Per Week: _____

Number of Fruits and Vegetables eaten a Week: _____