Client Information & Questionnaire

Name _____ Date:_____

Street Address _____ City _____

State_____ Zip Code_____ Contact Phone:_____

If this is a cell phone – do you send and receive texts? Yes No

Email _____ Do you Use Email regularly? Yes No

Sex: M F Age: _____ Birthdate _____

Height _____ Weight _____

Are you currently being treated for any medical condition? Yes No
If Yes, Explain:
_____

_____

_____

Indicate if you have had blood relatives with any of the following problems:

Cancer Yes No	Heart disease Yes No
High blood pressure Yes No	Diabetes Yes No
Obesity Yes No	Osteoporosis Yes No
Thyroid disorder Yes No	High cholesterol Yes No

Do you use tobacco in any way? Yes No
How much? _____

Did you recently stop smoking? Yes No

Do you enjoy physical activity? Yes No

Explain _____

_____

List any Food Allergies or Intolerances: _____

_____

List any Medications – Prescription or Other the Counter, Vitamins, or Supplements that you take regularly:

_____

_____

Do you follow a special dietary plan, such as, low cholesterol, kosher, vegetarian?
If Yes, Explain:

_____

_____

Have you ever followed a special diet? Yes No
If Yes, Explain:

_____

_____

Do you have any problems purchasing foods that you want to buy? Yes No

Are there certain foods that you do not eat? Yes No
If yes, Explain:

_____

_____

_____

Do you eat at regular times each day? Yes No

How often? _____

Do you drink alcohol? Yes No

How often?: _____

What changes would you like to make?

Improve my eating habits Improve my activity level
Learn to manage my weight Improve my cholesterol/triglyceride levels

Other _____

_____

Please add any additional information you feel may be relevant to understanding your nutritional health.

_____

_____

_____

_____

Are you employed? Yes No Occupation: _____

How many people in your household? _____ Ages?_____

Present marital status (circle one):
Single Married Divorced Widowed Separated Engaged It's Complicated

Who prepares most of the meals in your home? _____

Who shops?_____ How Often?_____

Do you use convenience foods daily? Yes No

How often do you eat out Daily Weekly Rarely?_____ What kind of Foods?_____

_____

Have you made any changes in your life previously that you feel good about?
Yes No

Who could support and encourage you to make new changes?

_____

How many hours a day do you spend on a computer? _____

Are you comfortable using internet tools? Yes No

What do you do when you are relaxing at home?

_____

_____

_____