|  |  |  |
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| **NAME:** | **AGE:** | **GENDER:**  |
| **INDICATE HOW OFTEN YOU CONSUME THESE FOODS BY PLACING AN "X" IN THE BOX** |
| **FOODS** | **DAILY** | **WEEKLY** | **LESS THAN ONCE PER WEEK** | **NEVER** |
| Whole grains (brown rice, quinoa, whole wheat bread, etc.) |  |  |  |  |
| Milk (regular, soy, almond, etc.) |  |  |  |  |
| Other dairy products (yogurt, cheese, etc.) |  |  |  |  |
| Red meat (beef)  |  |  |  |  |
| Chicken, turkey, pork  |  |  |  |  |
| Fish, seafood |  |  |  |  |
| Beans & peas (chickpeas, lentils, black beans) |  |  |  |  |
| Fruits  |  |  |  |  |
| Vegetables  |  |  |  |  |
| Healthy Fats (olive oil, avocados, nuts/seeds, or nut butter  |  |  |  |  |
| Fried foods  |  |  |  |  |
| Alcohol  |  |  |  |  |
| Other products not listed |  |  |  |  |
| **DO YOU HAVE ANY DIETARY CHOICES OR RESTRICTIONS WE SHOULD KNOW ABOUT?** |
| **DIETARY CHOICES** | **NO** | **YES** |
| Are you a vegetarian? |  |  |
| Are you a vegan? |  |  |
| Do you have any food intolerances? |  | If yes, please describe: |
| Do you have any food allergies? |  | If yes, please describe: |
| **LIST ALL THE SUPPLEMENTS YOU ARE TAKING OR HAVE TAKEN WITHIN THE LAST 6 MONTHS:** |
| **SUPPLEMENT** | **BRAND** | **CURRENT (x)** | **PAST SIX MONTHS (x)** |
| *Example: Multivitamin* | *One-a-day* | *x* |  |
|  |  |  |  |
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| **HYDRATION** |
| How much FLUID do you drink per day? |
| Have you ever experienced symptoms of dehydration? (ex: nausea, dizziness, headache, etc.) |
| Do you often experience muscle cramping as a result of exercise? |
| **EATING BEHAVIORS** | **NO** | **YES, PLEASE EXPLAIN** |
| **Do you limit/avoid nutrition groups (i.e. low carb, no dairy, no gluten, etc.)?** |  |  |
| **Do you skip any meals during the day?** |  |  |
| **Do you find eating to be stressful?** |  |  |
| **Do you eat differently on the weekend?** |  |  |
| **Have you ever worked with an RD or Nutritionist before?** |  |  |
| **Have you ever participated in a diet or diets?**  |  |  |

|  |  |  |
| --- | --- | --- |
| **NAME:** | **AGE:** | **GENDER:**  |
| **CURRENT CHALLENGES & GOALS** |
| **Any nutrition challenges you’re currently facing?** |
| **What is your biggest nutrition challenge?** |
| **What areas of nutrition would you like to improve upon?** |
| **Is there anything else that you feel we should know that is pertinent to your participation in this nutrition program?** |