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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?** | | | | | | |  |  | | | | | |

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| --- | --- | --- |
| **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?** | | |