

General Health

Given a 24hr day, how many hours do you sleep? _____

Is it enough? _____ Do you sleep through the night? _____

What time do you get out of bed each day? _____

How do you feel upon awaking from sleep? _____

When do you experience energy slumps? _____

When do you feel most alert, and function at your best? _____

Exercise Type	Frequency	Duration
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check conditions that apply to your immediate **family, and list the relative(s).**

Condition	Relative(s)
<input type="radio"/> CVD	_____
<input type="radio"/> High Blood Pressure	_____
<input type="radio"/> High Cholesterol	_____
<input type="radio"/> Stroke	_____
<input type="radio"/> Breast Cancer	_____
<input type="radio"/> Colon Cancer	_____
<input type="radio"/> Cancer (Other)	_____
<input type="radio"/> Prostate Cancer	_____
<input type="radio"/> Thyroid Problems	_____
<input type="radio"/> Diabetes	_____
<input type="radio"/> Alcoholism	_____
<input type="radio"/> Dementia	_____
<input type="radio"/> Autoimmune Disorder	_____
<input type="radio"/> Allergies	_____
<input type="radio"/> Other	_____

Nutrition:

How often do you eat out? (Daily, weekly)

What determines if you eat at home or out?

What food(s) do you crave?

When and why do you think you crave these foods?

Do you have any dietary restrictions due to religious obligation, food allergies medications, aversions, etc.?

What foods do you not like?

What food(s) should I not ask you to eliminate from your diet and why?

What diets have you followed in the past? What did you like/dislike about the diet?

About how much water do you consume in a day?

What foods do you eat regularly in each category, check all that apply (see examples).

Vegetables	Fruits	Meats,Poultry, Fish	Dairy	Sweets
<input type="radio"/> Broccoli <input type="radio"/> Cabbage <input type="radio"/> Carrot <input type="radio"/> Celery <input type="radio"/> Lettuces <input type="radio"/> Kale <input type="radio"/> Capsicum <input type="radio"/> Sweet Potato <input type="radio"/> Tomato <input type="radio"/> Garlic <input type="radio"/> Sprouts	<input type="radio"/> Bananas <input type="radio"/> Strawberries <input type="radio"/> Mangoes <input type="radio"/> Oranges <input type="radio"/> Apples <input type="radio"/> Grapes <input type="radio"/> Cherries <input type="radio"/> Grapefruit <input type="radio"/> Peaches <input type="radio"/> Pomegranate <input type="radio"/> Berries	<input type="radio"/> Beef <input type="radio"/> Pork <input type="radio"/> Chicken <input type="radio"/> Fish <input type="radio"/> Shellfish <input type="radio"/> Eggs <input type="radio"/> Other	<input type="radio"/> Milk <input type="radio"/> Butter <input type="radio"/> Cheese <input type="radio"/> Yogurt <input type="radio"/> Ice Cream <input type="radio"/> Other	<input type="radio"/> Candy Bars <input type="radio"/> Cakes,Pies <input type="radio"/> Chocolate <input type="radio"/> Candies <input type="radio"/> Other (list)

Grains	Breads	Nuts	Fast Food	Other (canned, frozen)
<input type="radio"/> Oats <input type="radio"/> Barley <input type="radio"/> Buckwheat <input type="radio"/> Amaranth <input type="radio"/> Quinoa <input type="radio"/> Millet <input type="radio"/> Rice <input type="radio"/> Rye	<input type="radio"/> Wheat Bread <input type="radio"/> Bagels <input type="radio"/> Muffins <input type="radio"/> Other	<input type="radio"/> Almonds <input type="radio"/> Hazelnuts <input type="radio"/> Peanuts <input type="radio"/> Chestnuts <input type="radio"/> Pistachios <input type="radio"/> Walnuts <input type="radio"/> Cashews <input type="radio"/> Pecans <input type="radio"/> Macadamias	<input type="radio"/> Hamburgers / Sandwiches <input type="radio"/> French Fries <input type="radio"/> Breakfast Sandwiches <input type="radio"/> Other (list)	

Alcohol _____ How much/day or week _____

Tobacco _____ How much/day or week _____

Recreational Drugs _____ How much/day or week _____

Caffeine _____ What and how much/day _____

Check all kitchen appliances you own:

- Juicer
- Blender
- Food processor
- Oven
- Stove top
- Food dehydrator
- Water filter/purifier

Describe your day, when and where do you typically eat your meals. Does work/ school/ other priority determine when and where you eat meals?

What kind of meal plan would you like?

- Specific. I want to be told what to eat for each meal.
- General. I want to have a list of choices for each meal.

What additional services do you need to ensure your success to this new lifestyle? Ask *about rates if you are interested in the following services:*

- Tour of the grocery store; how to read food labels; finding new products
- Explanation/sampling of new foods
- Cleaning out your kitchen/pantry- (what foods to keep and what foods to eliminate)
- Cooking lessons
- Referral to:

- I would like to be on your email list so I can receive updates on classes, recipe ideas, and general news about nutrition (coming soon, stayed tuned).