3100 Weslayan St. Suite 377
Houston, TX 77027
281-500-6001

Date: _____

Pre-Appointment Nutrition Client Questionnaire

Client Information

Name: _____

Phone number: _____ email: _____

Address (street, city and zip): _____

Date of birth: _____ Height: _____ Weight: _____ Age: _____ Gender: _____

How did you hear about our services? _____

Have you seen a nutritionist before? Yes [ ] No [ ]

What are your short-term health goals?

_____

What are your long-term health goals?

_____

What are your expectations for this visit?

_____

Medical History

Do you have any pre-existing medical conditions? Yes [ ] No [ ]
If yes, please list: _____

Have you had any surgeries or recent hospitalizations? Yes [ ] No [ ]
If yes, please list: _____

Do you or your family members have a medical history of:

Disorder	Self	Family	Disorder	Self	Family
Diabetes	[ ]	[ ]	High Cholesterol	[ ]	[ ]
Cancer	[ ]	[ ]	Eating Disorder	[ ]	[ ]
Heartburn	[ ]	[ ]	High Blood Pressure	[ ]	[ ]
Hyperthyroid	[ ]	[ ]	Heart Disease	[ ]	[ ]
Hypothyroid	[ ]	[ ]	Osteoporosis	[ ]	[ ]
Underweight	[ ]	[ ]	Food Allergies	[ ]	[ ]
Overweight	[ ]	[ ]	Digestive Problems	[ ]	[ ]
Obesity	[ ]	[ ]	Other	[ ]	[ ]

Are you taking any OTC or prescription medications? Yes [ ] No [ ]
If yes, please list: _____

Are you taking any vitamins, supplements, or herbs? Yes [ ] No [ ]
If yes, please list: _____

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(Females only) When did you begin your last menstrual cycle? _____

Are your cycles regular? Yes [ ] No [ ] Are you pregnant or trying to conceive? Yes [ ] No [ ]
Any history or current UTI's (Urinary tract infections) or Yeast infections? Yes [ ] No [ ]
Do you experience PMS or any significant cramping/bloating? Yes [ ] No [ ]
Have you ever been diagnosed with PCOS or fibroids? Yes [ ] No [ ]

_____

If menopausal, are you experiencing hot flashes, increased body fat, or other symptoms?

_____

(Men only) Any issues with libido, erectile function, testosterone levels? Yes [ ] No [ ]

Structural Health

Do you have any concerns or changes with your hair, skin, nails? _____

Any history or current rashes, hives, eczema, psoriosis? Yes [ ] No [ ]
If yes, please explain: _____

Any recurring injuries or neuromuscular pain? Yes [ ] No [ ]
If yes, please explain: _____

Any joint pain? Yes [ ] No [ ] If yes, where? _____

Any fluid retention? Yes [ ] No [ ] If yes, please specify: _____

Lifestyle

What is your marital status? _____ How many people live in your home? _____

What do you do for physical activity? _____

How often are you physically active? _____

Do you drink alcohol? Yes [ ] No [ ] If yes, how often/what kind? _____

Do you smoke? Yes [ ] No [ ] If yes, how often? _____

Do you use drugs of any sort? Yes [ ] No [ ] If yes, what kind & how often? _____

Do you consume…

Coffee? Yes [ ] No [ ] Frequency: _____

Caffeinated tea? Yes [ ] No [ ] Frequency: _____

Caffeinated soda? Yes [ ] No [ ] Frequency: _____

How many hours of sleep do you get each night? _____

Do you sleep well? Yes [ ] No [ ] Wake rested? Yes [ ] No [ ]
How would you describe your stress levels? _____

How do you cope with stress? _____

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Digestion

Do you follow a specific dietary plan? Yes [ ] No [ ]
Do you have difficulty swallowing? Yes [ ] No [ ]
Do you experience any reflux? Yes [ ] No [ ]
Do you experience any heartburn? Yes [ ] No [ ]
Do you suffer from (check all that apply): Constipation [ ] Loose stools [ ] [ ]
If so, how often? _____

Do you experience bloating, distention or gas/flatulence? Yes [ ] No [ ]
If you have bloating/distention, is it above or below the belly button? _____

Do you experience any pain or cramping digestively? Yes [ ] No [ ]
Have you ever taken a probiotic? Yes [ ] No [ ]
If yes, did you tolerate it? Yes [ ] No [ ]

Eating Habits

Do you follow a specific dietary plan? Yes [ ] No [ ]
If so, please explain: _____

Do you avoid certain foods? Yes [ ] No [ ]
Do you have any food allergies? Yes [ ] No [ ]
If yes, what? _____

Are there any foods you eat because they are "healtyh" but wish you enjoyed? Yes [ ] No [ ]
If so, what? _____

Do you have any favorite foods or foods you consume daily/recurring? Yes [ ] No [ ]
If so, what? _____

Have you followed a nutrition plan in the past? Yes [ ] No [ ]
Why? _____

If yes, were you successful in achieving your goal? Yes [ ] No [ ]
If not, what went wrong? _____

Habits and Preferences (check all that apply)

Eating habits: Binge eater [ ] Stress [ ] Borerdom [ ] Loneliness [ ] Social [ ] Distracted (TV, Working, Driving) [ ] Other: _____

Do you suffer from uncontrollable cravings, or do you feel out of control around certain foods? Yes [ ] No [ ]
If yes, please explain and/or identify the foods you tipically crave:

_____

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Do any of these apply to you? Check all that apply.

[ ] Eating large portions	[ ] Skipping breakfast	[ ] Use a sugar substitute
[ ] Eating too much sugar	[ ] No exercise	[ ] Consume juice, sweet tea, or soda
[ ] Eating too many fatty foods	[ ] Don't drink enough water	[ ] Drink diet beverages
[ ] Use too much salt	[ ] Eat when not really hungry	[ ] Consume caffeinated drinks
[ ] Eat too fast/not eat mindfully	[ ] Eat a lot of fast food	[ ] Use frozen meals
[ ] Eat a lot of junk food	[ ] Eat little or no fruid	[ ] Suffer from food allergies
[ ] Eat little or no vegetables	[ ] Skip meals often	[ ] Food avoidances

In your household, who plans meals/cooking/grocery shopping? _____

How frequently do you eat meals away from home (at restaurants, coffee shops, or fast food establishments)?
Everyday [ ] 5 times per week [ ] 3-4 times per week [ ] 1-2 times per week [ ] Never [ ]

Eating attitudes

Do you believe that you are under or overeating? Yes [ ] No [ ]
If so, what situations or emotions trigger these habits? _____

Do you have any cravings? Yes [ ] No [ ]
If so, when do you experience these cravings? _____

Are there specific triggers for your food cravings? Yes [ ] No [ ]
Do you feel like you have a positive body image? Yes [ ] No [ ]
What is your support network like? _____

In one sentence, how would you describe your food/dietary decisions? (ex. convenience based, taste driven, socially impacted) _____

Please complete the sentence, "For me, an ideal meal would be…"

_____

Please rank your top three health concerns in order of greatest importance:

1. _____
2. _____
3. _____

Any other important information:

_____