



Nutrition Questionnaire

Please answer the following questions by placing a block capital 'X' next to your answer, highlighting or by filling in the space provided. Please bring completed nutrition questionnaire to scheduled appointment. Thank you.

Name:

Address:

Telephone:

E-mail address:

Age:

Height:

Weight:

1. Are you currently taking any medications or birth control?

2. Do you have a family history of any of the following health conditions?

Heart Disease
High Blood Pressure
High Cholesterol
Diabetes
Hypoglycemia

Cancer
Obesity
Osteoporosis
Arthritis

3. Are you currently taking any vitamins, minerals or other natural supplements?

1. Yes
2. No
3. Sometimes

If so, please list supplements including brand and dosage, or please bring supplements to appointment.

4. What are your main nutritional concerns and goals?

5. What has stopped you from reaching those goals in the past?

6. Which body type most closely matches yours?



Apple shape

Tends to store fat around the belly and chest.



Pear shape

Holds the majority of fat in the lower body: hips, buttocks, saddlebags.



Proportionate shape

Has equal fat distribution: gains and loses weight evenly.

7. Are you currently physically active?

1. Yes
2. No
3. Sometimes

If yes, please explain.

8. How much sleep on average do you obtain each night?

1. 10 or more hours per night
2. 8-10 hours per night
3. 7-8 hours per night
4. 6-7 hours per night
5. Less than 5
6. Not sure- do not sleep well throughout night.

9. How much water do you drink each day?

1. Less than ½ liter
2. ½-1 liter
3. More than 1 liter

10. How many cups of coffee, black tea or caffeine containing beverages do you drink each day?

1. 4-6
2. 3 -4
3. 2-3
4. 1 or fewer

11. How much soda, fruit juice or sugary drinks do you normally have each day?

1. More than 3
2. 2-3
3. 1 or fewer

12. How many alcoholic beverages do you consume on a weekly basis?

1. More than 5
2. 3-4
3. 2 or fewer
4. None

13. Do you eat breakfast every day?

1. Yes
2. No
3. Sometimes

14. Please describe a typical day's menu:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

15. Do you have any food allergies/ intolerances?

16. Do you suffer a loss of energy in the middle of the afternoon?

1. Often
2. Sometimes
3. Never

17. What Blood Type are you?

- | | |
|--------|-------------|
| 1. A | 4. B |
| 2. A/B | 5. Not Sure |
| 3. O | |

18. How many pieces of fresh or frozen fruit do you eat each day? (a portion based on ½ cup)

1. More than 3
2. 1-3
3. 1 or fewer

19. How many portions of fresh or frozen vegetables do you eat each day? (a portion based on ½ cup)

1. More than 7
2. 4-7
3. 2-4
4. 1 or less

20. How often do you eat after 8 o'clock in the evening?

1. Regularly
2. Occasionally
3. Never

21. Do you use artificial sweeteners or use products containing artificial sweeteners?

1. Regularly
2. Occasionally
3. Never

22. How would you rate your current stress level?

1. Low
2. Medium
3. High
4. Very High

**Thank you for taking the time to fill out
this Nutrition Questionnaire. 😊**



Kathy Smart is a Registered Nutritional Consultant with
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