Nutritional Questionnaire

Name:_______________________________________ Date of Birth: ______________________________

Current Weight: ________ Goal Weight:________

List Current Medications and Daily Doses:

1. Do you prefer several small meals or three large ones?
2. Do you drink regular coffee or decaf on a regular basis?
3. Do you prefer condiments such as mayonnaise or spices? If so, please list.
4. Do you have trouble sleeping at night?
5. Would other people view you as even-keeled, or temperamental?
6. After a meal, are you bloated or constipated?
7. Do you have any food allergies? If yes, please explain.
8. Do you experience a drop in energy levels throughout the day?
9. After eating a meal high in sugar, do you experience an energy drop?
10. Are you prone to getting cold or flu symptoms?
11. Have you had any surgeries that might impair the digestion process, such as gastric bypass or a gallbladder removed?
12. Are you currently taking any thyroid medication or anything for a metabolic disorder?
13. Do you find yourself binging on junk food because of stress or emotional distress?
14. Are you ready to consider a lifestyle change to get the results you want?
15. Are you open to alternative supplementation in order to balance out nutritional deficiencies?
16. Would you consider a nutritional program if you knew it was going to boost your energy levels and make you feel good?