

Date: _____

SELF REPORTED NUTRITION & LIFESTYLE FORM

Name _____ Phone _____

Address _____

Email _____

Occupation _____ Age _____ Height _____

Weight _____ Desired Weight _____ Weight History _____

How many hours of physical activity do you get each week and what type?

Do you have any physical limitations? _____

List past medical problems. _____

List current medical problems and complaints. _____

List all medications including vitamins and herbs. _____

Do you smoke? _____ How much? _____ How long? _____

How many alcoholic beverages do you have a week? _____

Who does the shopping? _____ Cooking? _____

How ofte do you eat out each week? _____

List any food allergies _____

Please write out your nutrition and lifestyle goals.

List a typical day's food intake including amounts, time eaten, and all liquids consumed including water. Include all meals and snacks eaten.
