

Nutritional Questionnaire

Date: _____

Name _____ Addr: _____ City _____ Zip _____

Day Phone _____ Eve _____ Ht _____ Wt _____ Sex _____

Birth Date _____ Usual Weight _____ When _____ Goal Weight _____

E-Mail _____ **Impedance** _____ (We will measure **metabolic rate**.)

Have you ever consulted a **nutrition expert** (someone who specializes only in nutrition) for nutrition counseling **in the past?** (not commercialized weight loss programs or a personal trainer) _____ **Who?** _____

Most Important Reason(s) For Considering Nutrition Counseling (start with most important) _____

What **Nutritional Programs or Diets Have You Tried In The Past?** (If any) _____

Do you think medications, nutrition products, or most commercial weight loss programs without lifestyle counseling are effective? _____

Have you ever had you're metabolic rate measured? _____ **Lean Muscle Mass?** _____

Do you know how many grams of protein you need per day? _____ **if so** _____ **grams**

ANSWER 1 to 10. 1 = LOW IMPORTANT 5 = MEDIUM IMPORTANT 10 = VERY IMPORTANT

Is nutrition counseling for **cancer, heart disease, and disease prevention** important? _____

Is nutrition counseling for **weight management (reduce body fat & increase muscle)** important? _____

Is nutrition counseling for **weight gain(sports nutrition) (lean mass increase)** important? _____

Is nutrition counseling for **anti-aging - to look and feel younger** important? _____

Is nutrition counseling to **have more energy** and better workouts? _____

How many **pounds weight loss or gain** would you prefer **each week or month (please circle)** ? _____ **lbs**

Please complete both sides of Questionnaire

**Lifestyle Nutrition
SCREENING QUESTIONNAIRE**

The Lifestyle Nutrition Program provides state-of-the-art Analysis including Health Risk Appraisal, Body Composition Analysis and Individualized Nutrition and Exercise Recommendations.

The information requested on this questionnaire is important to develop your customized program. All information and results are CONFIDENTIAL.

Today's Date ___/___/___

Last Name _____ First _____ MI _____

Address _____

City _____ State _____ Zip _____

Social Security Number _____ - _____ - _____

Phone Number H (_____) _____ - _____ W (_____) _____ - _____

Physician's Name _____

Physician's Number _____

May we send your physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency:

Name _____

Relationship _____ Phone (_____) _____ - _____

Your Date of Birth _____ / _____ / _____ Age _____ Sex M F (Circle one)
Month Date Year

Disclaimer

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program or taking any supplements. I take full responsibility for my participation in any of these programs for any claims for injuries or illness that may result from my participation in any of their programs.

Signature

Date

Witness

Date

(Proceed to Side 2)

MEDICAL HISTORY

Includes American College of Sports Medicine
Coronary Risk Factors

Do you now, or have you had in the past:

- | | NO | YES |
|---|--------------------------|--------------------------|
| 1) History of heart problems, recurring chest pain, heart murmur, or stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Diagnosis of Hypertension or take medicine for same | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Diabetes Mellitus | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Asthma, breathing or lung problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Cancer (other than skin) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Seizures, seizure medication, neurological problems or severe dizziness | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Gallbladder disease or intestinal problems | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Back problem, joint or muscle disorder still affecting you | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Recent surgery (last 12 months) | <input type="checkbox"/> | <input type="checkbox"/> |
| 10) Hernia or any condition that may be aggravated by lifting weights | <input type="checkbox"/> | <input type="checkbox"/> |
| 11) Physician's advice not to exercise | <input type="checkbox"/> | <input type="checkbox"/> |

WOMEN ONLY:

- 12) Are you pregnant, lactating or anticipating becoming pregnant? NO YES
- _____

If your answer is YES to any question above, give *brief* explanation: _____

- | | | | |
|--|--------------------------|--------------------------|--------------------|
| 13) History of total Cholesterol greater than 200 mg/dl | <input type="checkbox"/> | <input type="checkbox"/> | |
| 14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55 | <input type="checkbox"/> | <input type="checkbox"/> | |
| 15) History of cigarette smoking | <input type="checkbox"/> | <input type="checkbox"/> | |
| 16) Do you take vitamins? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 17) Are you allergic to soy? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 18) Are you allergic to lactose / dairy products? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 19) Are you taking any medications? | <input type="checkbox"/> | <input type="checkbox"/> | If so, what? _____ |
- _____

SIGNATURE