

Receipt # \_\_\_\_\_  
Initials \_\_\_\_\_  
Date Purchased \_\_\_\_\_

**FITNESS SERVICES  
NUTRITION CONSULTATION QUESTIONNAIRE**

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

AGE: \_\_\_\_\_ HEIGHT: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

1) Why are you interested in meeting with a nutrition specialist? What specific nutrition/health goals do you have? (Be specific as possible.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2) What are your concerns or barriers for reaching your goals?  
\_\_\_\_\_ Time for meal planning/Preparation \_\_\_\_\_ Limited funds/Budget  
\_\_\_\_\_ Motivation/Emotional Factors \_\_\_\_\_ Lack of Nutrition Knowledge  
\_\_\_\_\_ Other (Please Explain Below)  
\_\_\_\_\_  
\_\_\_\_\_

3) General Questions:  
Do you have any food allergies or restrictions? \_\_\_\_\_, if so please list: \_\_\_\_\_  
Do you currently take any supplements/vitamins/herbs? \_\_\_\_\_, if so please list: \_\_\_\_\_  
Do you have any family history of medical conditions? \_\_\_\_\_, if so please list: \_\_\_\_\_  
Do you take any medications that may affect your diet? \_\_\_\_\_, if so please list: \_\_\_\_\_

4) Describe the following aspects of your current diet; please use the terms *high, low, or normal*.

_____ Fat Intake	_____ Protein Food Intake
_____ Sweets Intake	_____ Fruit/Vegetable Intake
_____ Salt/Sodium Intake	_____ Breads/Grains Intake
_____ Caffeine/Carbonated Beverage Intake	_____ Fiber Intake
_____ Dairy Food/Calcium-Rich Food Intake	_____ Water Intake

Please circle your answer for the following.



Do you have *irregular* or *regular* meal patterns?

Do you skip any meals? *Yes* or *No*.

- 5) Check any specific nutrition topics you would like to be covered at your nutrition consultation.

<input type="checkbox"/> Basic Nutrition Guidelines	<input type="checkbox"/> Diet for Hypoglycemia
<input type="checkbox"/> Safe Weight Management Guidelines	<input type="checkbox"/> Tips for Eating on the Go
<input type="checkbox"/> Restaurant and Fast Food Guidelines	<input type="checkbox"/> Balance Fat Intake
<input type="checkbox"/> Decreasing Cholesterol	<input type="checkbox"/> Label Reading
<input type="checkbox"/> Weight Gain Guidelines	<input type="checkbox"/> Increasing Fiber Intake
<input type="checkbox"/> Osteoporosis Prevention	<input type="checkbox"/> Meal Planning/Recipes
<input type="checkbox"/> Sports Nutrition	<input type="checkbox"/> Vegetarian Diet Guidelines
<input type="checkbox"/> Portion Sizes	<input type="checkbox"/> Emotional Eating/Hunger
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Eating Disorders &
_____	Resources

- 6) If you are currently participating in a regular exercise program, please fill out the following information.

Cardiovascular: Days per Week: \_\_\_\_\_ Duration: \_\_\_\_\_  
Activity: \_\_\_\_\_

Resistance Training: Days per Week: \_\_\_\_\_ Duration: \_\_\_\_\_

- 7) If weight loss is a goal please fill out the following information.

Recent weight gain/loss of \_\_\_\_\_ lbs over period \_\_\_\_\_ months/years.  
Highest adult weight: \_\_\_\_\_ Lowest adult weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_  
Have you been on any previous diets, what diets? Was it successful? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

