NUTRITION INTAKE QUESTIONNAIRE

Name _____ Age_____ Ht_____ Wt_____

Address _____

City _____ State _____ Zip Code _____ Country _____

Phone # _____ Email _____

TYPICAL BREAKFAST:

_____

TYPICAL LUNCH:

_____

TYPICAL DINNER:

_____

TYPICAL IN-BETWEEN MEAL FOODS:

_____

FATS AND OILS EATEN DAILY:

_____

SUGAR AND WHITE FLOUR EATEN DAILY:

_____

FRUITS AND VEGETABLES EATEN DAILY:

_____

LEGUMES (BEANS, LENTILS) EATEN DAILY:

_____

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WHOLE GRAINS EATEN DAILY (GERM AND BRAN):

_____

NUTS AND SEEDS CONSUMED DAILY:

_____

SEAFOOD, MEAT, POULTRY, EGGS, AND DAIRY EATEN DAILY:

_____

BINGE AND COMFORT FOODS:

_____

SUSPECTED REACTIVE FOODS:

_____

NUMBER AND USUAL TIME OF DAILY MEALS/SNACKS EATEN:

_____

RESTAURANTS AND GROCERY STORES FREQUENTED:

_____

HEALTH CONCERNS

Check any known or suspected allergies, intolerances, or sensitivities to the following:

☐ Food additives	☐ Dairy products	☐ Peanuts/ Nuts/ Seeds	☐ Soy	☐ Sugar
☐ Chocolate	☐ Corn products	☐ Wheat products	☐ Eggs	☐ Oranges/ O.J.
☐ Shellfish/Fish	☐ Yeast	☐ Dust / Mites	☐ Mildew / Mold	☐ Chlorine / Pools
☐ Lawn/Garden	☐ Pollen /Hay fever	☐ Perfumes/ Cologne	☐ Other _____	

OTHER ITEMS TO CONSIDER: (TO BE DISCUSSED IN DETAIL)

_____

List all current supplements (vitamins, minerals, herbs, fatty/amino acids, greens, etc.)

	BRAND NAME	DOSE	QUANTITY PER DAY
1.			
2.			
3.			
4.			
5.			

List all current prescription and non-prescription medications and the reason for use:

MEDICATION NAME	DOSE	CONDITION BEING TREATED
1.		
2.		
3.		
4.		
5.		

Recurrent conditions - eyes, nose, throat, lungs, digestive or urinary tract, skin, weight, insomnia, etc.:

_____

_____

_____

_____

CHECK ANY OF THE FOLLOWING, POSSIBLY RELATED TO MEAL/SNACK TIMING AND COMPOSITION:

☐ Anxiety, fear	☐ Anger, irritability, aggressiveness	☐ Mood swings	☐ Headaches/Body aches
☐ Unsocial	☐ Isolative	☐ Oppositional/Defiant	☐ Injury to self or others
☐ Depression	☐ Poor concentration	☐ ADHD	☐ Listless
☐ Poor memory	☐ Indecisive	☐ Lack of impulse control	☐ Mental fog
☐ Hyper-talkative	☐ Unable to complete projects	☐ Sleep disturbances	☐ Picky eating

OTHER ITEMS TO CONSIDER: (TO BE DISCUSSED IN DETAIL)

_____

_____

_____

EXERCISE:

_____

_____

_____

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