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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