



**custom built nutrition**  
*built by science. made for you.*

## QUESTIONNAIRE:

Client Health History; Complete Prior to Nutrition Meeting

First Name:

Last Name:

e-mail:

Address:

City:

State:

Zip Code:

Home Phone:

Other Phone:

### general information:

Occupation:

Height:  Male:  Female:  Date of Birth:

Current Weight:  Desired Weight:

Bone Structure: Small  Medium  Large

Activity Level: Very Low  Low  Medium  High  Very High

Do you smoke? No:  Yes:  If Yes, Packs/Day:

Do you drink alcohol? No:  Yes:

If Yes,  
What is your consumption? Beer:  oz/week Wine:  oz/week Liquor:  oz/week

## dietary habits:

20. Have you tried "dieting" before? \_\_\_\_\_ n(explain) \_\_\_\_\_
21. Do you skip meals when you diet? \_\_\_\_\_
22. Do you have mid morning and afternoon dips in energy? \_\_\_\_\_
23. How many meals (on average) do you consume daily? \_\_\_\_\_
24. Do you get hungry between meals and snack? \_\_\_\_\_
25. What meal is your biggest? \_\_\_\_\_
26. How often do you consume any dairy? (explain) \_\_\_\_\_
27. How much water do you drink daily? \_\_\_\_\_
28. Do you pay attention to your "trigger point" when eating? (the feeling of being full)
29. How many times have you lost or gained more than 20 lbs (not incl. pregnancies)
30. Are you a sugar, salt, or fat craver? \_\_\_\_\_
31. Are you allergic to any foods? \_\_\_\_\_
32. Do you have a lactose intolerance?
33. Are there any foods you refuse to (or do not) eat? \_\_\_\_\_

## Physique Goals:

1. What are your diet goals?
  - A. Lose a lot of weight (more than 20 pounds)
  - B. Lose a little weight
  - C. Maintain weight
  - D. Improve healthOther (Add detail where you feel necessary): \_\_\_\_\_  
\_\_\_\_\_

2. How would you rate your physical activity level?
  - A. Sedentary
  - B. Light
  - C. Moderate
  - D. ActiveDescribe activity/exercise; give minutes per day and weekly amount : \_\_\_\_\_

3. When you eat out, what kind of restaurant do you prefer? (check all that apply)
  - A. Italian
  - B. Asian
  - C. Greek or Middle Eastern
  - D. American
  - E. Mexican
  - F. if fast food, give names:

Details: \_\_\_\_\_

4. Are you at risk for or concerned about any of the following conditions? (check all that apply)

- |                                    |               |
|------------------------------------|---------------|
| Diabetes                           | Heart Disease |
| Heartburn/GERD                     | Depression    |
| Hypertension (High Blood Pressure) | None          |

Notes:

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5. Use below space or attach a food log for a minimum of 2 days. Do not change anything about your current eating habits for these two days. This is critical. Log basic foods, snacks, drinks and even water. Try to include any relevant details and basic amount when appropriate.

TIME	FOOD/FOODS	DETAILS

(Use more paper if necessary.)

**Please fax this completed Questionnaire AT LEAST ONE DAY IN ADVANCE to 909-494-7685**

**Attention: Tracey/my completed Questionnaire**

**Please do not hesitate to contact me with any questions prior to your consult.**

**Thanks**

**909-913-2022**

**Email: traceyleemartin@msn.com**