Nutrition Questionnaire

Date:______________________________
Name: ____________________________
Address:___________________________
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Age:______________________________
Daytime Telephone:_________________
Evening Telephone:_________________
Relationship Status:_________________

Please indicate any of the following health conditions you currently have or have had:

_ Anemia
_ Angina
_ Arrhythmias
_ Arthritis/Joint Pain
_ Asthma
_ Back Pain
_ Coronary Artery Disease /Congestive Heart Failure /Heart Attack /Heart Surgery
_ Diabetes
_ Gallstones
_ Gastric Bypass/Bariatric Surgery
_ Hernia
_ Hypertension/High Blood Pressure
_ Irritable Bowel Syndrome/Crohn's
_ Lung Disease/COPD/Emphysema
_ Osteoporosis/Bone Disease
_ Problems with vision/hearing
_ Shortness of Breath
_ Stroke
_ Thyroid Disease
_ Ulcers/Reflux (GERD)

Please indicate any prescription medications you are currently taking:
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Please indicate any over-the-counter vitamins, minerals, herbals you are taking:
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Please discuss why you have chosen to pursue nutrition counseling at this time:
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Please discuss your current nutrition-related goals and expectations for treatment:
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Please discuss how ready you feel you are to make changes in your lifestyle and eating habits:
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