Lifestyle Nutrition, Inc **Offices - Broward, Palm Beach, Dade** ***It's a Lifestyle...not a diet!***

www.AboutMyDiet.com **Individualized Nutrition Counseling** **954-561-0166**

Nutritional Questionnaire

Date:_____

Name_____Addr:_____City_____Zip_____

Day Phone_____Eve_____Ht_____Wt_____Sex_____

Birth Date_____Usual Weight_____When_____Goal Weight_____

E-Mail_____ **Impedance**_____(We will measure **metabolic rate**.)

Have you ever consulted a **nutrition expert (someone who specializes only in nutrition) for nutrition counseling in the past?** (not commercialized weight loss programs or a personal trainer)**_____Who? _____.**

Most Important Reason(s) For Considering Nutrition Counseling (start with most important)_____

_____.

What **Nutritional Programs or Diets Have You Tried In The Past**? (If any)_____

_____.

Do you think medications, nutrition products, or most commercial weight loss programs without lifestyle counseling are effective? _____.

Have you ever had you're metabolic rate measured?_____ Lean Muscle Mass?_____

Do you know how many grams of protein you need per day?_____if so_____grams

ANSWER 1 to 10. 1 = LOW IMPORTANT 5 = MEDIUM IMPORTANT 10 = VERY IMPORTANT

Is nutrition counseling for **cancer, heart disease, and disease prevention** important? _____

Is nutrition counseling for **weight management (reduce body fat & increase muscle**) important? _____

Is nutrition counseling for **weight gain(sports nutrition) (lean mass increase**) important? _____

Is nutrition counseling for **anti-aging - to look and feel younger** important? _____

Is nutrition counseling to **have more energy** and better workouts? _____

How many **pounds weight loss or gain** would you prefer **each week or month (please circle)** ? _____**lbs**

Please complete both sides of Questionnaire

Lifestyle Nutrition
SCREENING QUESTIONNAIRE

The Lifestyle Nutrition Program provides state-of-the-art Analysis including Health Risk Appraisal, Body Composition Analysis and Individualized Nutrition and Exercise Recommendations.

The information requested on this questionnaire is important to develop your customized program. All information and results are CONFIDENTIAL.

Today's Date ___/___/___

Last Name_____ First_____ MI_____

Address_____

City_____ State_____ Zip_____

Social Security Number_____-_____-_____

Phone Number H (_____)_____-_____ W (_____) _____-_____

Physician's Name_____

Physician's Number_____

May we send your physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency:

Name_____

Relationship_____ Phone (_____)_____-_____

Your Date of Birth _____/_____/_____ Age_____ Sex M F (Circle one)
Month Date Year

Disclaimer

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program or taking any supplements. I take full responsibility for my participation in any of these programs for any claims for injuries or illness that may result from my participation in any of their programs.

_____ _____
Signature Date

_____ _____
Witness Date

(Proceed to Side 2)

MEDICAL HISTORY

Includes American College of Sports Medicine
Coronary Risk Factors

Do you now, or have you had in the past:	**NO**	**YES**
1) History of heart problems, recurring chest pain, heart murmur, or stroke	☐	☐
2) Diagnosis of Hypertension or take medicine for same	☐	☐
3) Diabetes Mellitus	☐	☐
4) Asthma, breathing or lung problems	☐	☐
5) Cancer (other than skin)	☐	☐
6) Seizures, seizure medication, neurological problems or severe dizziness	☐	☐
7) Gallbladder disease or intestinal problems	☐	☐
8) Back problem, joint or muscle disorder still affecting you	☐	☐
9) Recent surgery (last 12 months)	☐	☐
10) Hernia or any condition that may be aggravated by lifting weights	☐	☐
11) Physician's advice not to exercise	☐	☐
WOMEN ONLY:		
12) Are you pregnant, lactating or anticipating becoming pregnant?	☐	☐

_____

If your answer is YES to any question above, give *brief* explanation:_____

_____

13) History of total Cholesterol greater than 200 mg/dl	☐	☐
14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55	☐	☐
15) History of cigarette smoking	☐	☐
16) Do you take vitamins?	☐	☐
17) Are you allergic to soy?	☐	☐
18) Are you allergic to lactose / dairy products?	☐	☐
19) Are you taking any medications?	☐	☐

If so, what? _____

_____

_____
SIGNATURE

TYPICAL AVERAGE Daily Food Log (1 day- Min) *Name*_____

Please include Meals, Snacks, Beverages & Estimate Portion Sizes

Time	Food Eaten	Serving Size	Home or Restaurant

IDEAL BEST DAY Daily Food -1 day- **OPTIONA**L BUT VERY HELPFUL TO DOCUMENT

Please include Meals, Snacks, Beverages & Estimate Portion Sizes

Time	Food Eaten	Serving Size	Home or Restaurant