CITRUS MEDICAL

NUTRITION QUESTIONNAIRE

Date | Client Name

Gender | DOB

General Information

Home Phone | Cell Phone | Email Address

Address

City | State. | ZIP Code

Occupation/Business Type

Additional Information (Seniors/Military/etc.) | Service Requests

Other/Special Requests | Availability for Follow-ups

Previous Customer? | Referred by

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Health History

Do you currently have any of these illnesses or have a familial history of any of them?(check all that apply)

Diabetes☐ Hypertension☐ Heart Disease☐ Hyperlipidemia☐ Insomnia☐ Others……

1. What do you hope to achieve from this exercise? ……..
2. Do you currently take any supplements or vitamins? ……
3. If yes, list them please: ……
4. ……

   …….
5. Height….FT…….IN Weight: ……..LBS What is your desired weight? ……LBS
6. Do you drink alcohol? Socially☐ No☐ Always☐
7. If you do drink, how many servings of alcohol do you drink in one sitting (1 serving= 12oz beer, 5oz wine, 1oz liquor)? …….serving/s
8. Do you smoke? Yes☐ No
9. If you do smoke, how many packs a day? 1 pack☐ < 1pack ☐ >1 pack☐ social smoker☐

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Dietary Habits

Please check all that applies to you:

1. Do you have any food allergies or intolerances? Yes☐ NO☐
2. How do you rate your diet? Excellent☐ Good☐ Fair☐ Poor☐
3. Do you think you are overeating or undereating? Yes☐ No☐
4. Do you drink enough water daily? Yes☐ No☐
5. What is the estimated No of ounces of water you drink per day? ……..
6. Are you currently on special diet? Yes☐ No☐
7. If yes, what diet are you on ……
8. What is the normal meal pattern for you? (Check all that apply) Breakfast☐ Brunch☐ Lunch☐ mid-afternoon snack☐ Dinner☐ After-dinner snack☐
9. Have snack cravings☐ Eat junk food☐ Eat fatty foods☐ Consume caffeine☐ Beverages/Juices☐ Use sugar substitutes(aspartame,stevia,etc.)☐ Consume too much salt☐ Vegetables☐ Desserts☐
10. How often do you eat fast foods? Never☐ Sometimes☐ Daily☐ 3 times/week☐ 4 times/month☐

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Physical Activity

1. Do you have access to exercise?(gym, parks, pools, etc) Yes☐ No☐
2. Do you currently exercise? Yes☐ No☐
3. If Yes, how frequent? days/week…….. days/month……Session duration……..
4. Please list the type/s of exercise/s you do

   ……

5. How many hours do you sleep per day? (check the one that apply) <6☐ 6-8 ☐

   8-10☒ >10☐

Please list your typical day menu on the table below:

Time	Food/Beverage	Quantity
Breakfast		
Brunch		
Lunch		
Snack		
Dinner		
Snack		

Signature…….. Date ……

For office use only

Reviewed by…….. Date: ……