Customized Nutrition Plan Information Form

In order to get the best idea of what your goals are, please fill out the form below to your best ability. I will use this information to help tailor your customized nutrition plan to your needs. Please print and fill out the form and email it to me at: contact@balancedbodiesnutrition.com

Client Name:

Date:

Age:

Height:

Current Weight:

Weight 3 months ago:

Weight 6 months ago:

Weight 1 year ago:

1. **Describe your current weight (circle one):**

a. Very overweight/obese
b. Slightly overweight
c. Healthy weight
d. Underweight

2. **What is your goal weight?**

3. **Do you feel weight affects your daily activities (circle one)**
    a. All the time
    b. Often
    c. Rarely
    d. Not at all

4. **Please briefly explain your reason for seeking a dietitian.**

5. **Have you consulted with a dietitian before? If so, what did you consult the dietitian for? Was it helpful? Please explain your experience.**

6. **List your top 3 health & wellness concerns in order of importance.**
    1.

    2.

    3.

7. **Circle your main motivators for changing your diet.**

    a. Blood sugar control (Type 2 Diabetes)
    b. Cholesterol levels
    c. High blood pressure
    d. Weight loss
    e. Increased energy
    f. Improved self-confidence
    g. Prevention of disease
    h. OTHER (please specify):

8. **On a scale of 1-10 (1 being not at all and 10 being ready today) How ready are you to make lifestyle and diet changes for your health? (circle your answer)**

< 1 2 3 4 5 6 7 8 9 10 >

9. **Have you tried making changes to your diet in the past? If so, what have you tried?**

10. **What obstacles have you faced or might you face when trying to improve your diet? (circle all that apply)**
    a. Emotional stress
    b. Work schedule/requirements
    c. Lack of support from relatives/friends/coworkers
    d. Lack of time to prepare healthy meals
    e. Lack of money to buy nutritious foods
    f. Frequent travel
    g. OTHER (please specify)

11. **Do you smoke?**
    If yes, how many cigarettes/cigars per day?

12. **Do you drink alcohol?**
    If yes, how often do you consume alcohol (circle your answer)
    a. Daily
    b. A few times per week
    c. A few times per month

13. How often do you consume soda or sweetened beverages like tea, lemonade, or frappuccino (circle)?

Never daily a few times per week a few times per month

14. **Do you often overeat? (circle)** Yes No

If so, how often and why do you think you overeat?

15. What types of food do you typically crave (circle)?

a. Sweets/desserts
b. Chocolate
c. Bread/pasta
d. Fried foods/salty foods
e. Dairy
f. Meats
g. Alcoholic beverages

16. How often do you eat at home/ cook your own meals (circle)?

a. All meals
b. 1-2 times per day
c. 1 time per day
d. Rarely

17. Who does the cooking/food shopping?

18. Please rate your energy level (circle)

a. Excellent
b. Good
c. Fair
d. Poor

19. Please rate your quality of sleep (circle)

a. Excellent
b. Good
c. Fair
d. Poor

20. How many hours of sleep do you get per night?

21. Please write how many dates a week you exercise, how long each session lasts, and what you do for exercise:

22. Please list any food allergies/sensitivities you have as well as certain foods you avoid for religious or personal reasons:

23. Please list any medications and/or supplements you are taking right now.

24. Is there anything else you would like to share with your Dietitian?

Thank you very much!

This information will be kept confidential and will be used to provide you with a customized meal plan and for any follow-up counseling sessions that may occur.