Your Village Consulting

Nutritional Counseling Questionnaire

Name: _____

Address: _____

Email address: _____ How often do you check email? _____

Telephone – Work: _____ Home: _____ Cell: _____

Age: _____ Height: _____ Date of Birth: _____ Place of Birth: _____

Current weight: _____ Weight six months ago: _____ One year ago: _____

Would you like your weight to be different? _____ If so, what? _____

Relationships status: _____ Children? _____

Occupation: _____ Hours of work per week: _____

Do you sleep well? _____ Do you wake up at night? _____ What times? _____

To urinate? _____ What time do you generally get up in the morning? _____

What blood type are you? _____ What is your ancestry? _____

Women: Are your periods regular? _____ How many days is your flow? _____ How frequent? _____

Painful or symptomatic? _____ Please explain: _____

Do you take any supplements or medications? If so, which? _____

How is the health of your mother? _____

How is the health of your father? _____

Please list your Personal Health Goals (lose weight, increase energy, recovery from health issue, etc): _____

_____

Lifestyle History

1. How many glasses of water do you drink per day and what is the source (tap, bottled, etc)? _____
2. How much coffee do you drink? cups per day_____ cups per week_____ Decaf or regular?____
3. How much tea do you drink? cups per day_____ cups per week_____ Decaf or regular?____
4. How much alcohol do you drink? _____drinks per day _____ drinks per week
5. How much soda do you drink? _____ drinks per day____# of regular/day ____# of diet/day
6. What is your relationship with sugar? ___eat daily___ occasionally___ rarely ___never ____tend to binge on it when I do eat sugar
7. What time of day do you have sugar cravings? ___morning ____mid afternoon ____after dinner_____ all the time
8. Do you exercise regularly? ___consistently, 5-7 days/wk ____moderately, 3 days/wk____occasionally 1-2 days/wk ____rarely ____never
9. What does a typical week of movement look like? Describe type of activity and duration. _____ _____ _____
10. Do you smoke cigarettes?_____ If so, how much?____ Did you ever smoke?_____
11. Do you use artificial sweeteners? If so, which one?_____ How often/week?_____
12. Do you find it difficult to relax? How do you relax?_____ _____
13. How often do you have bowel movements _____daily _____weekly
14. Do you have any trouble with _____constipation _____ diarrhea_____or both. How long has this been a problem?_____
15. How would you rate your energy level on a scale of 1-10 (10 being the highest)? _____ Has this changed over the past few years? Please explain:_____ _____

Food Lifestyle

1. Please use this page to help me understand your current eating patterns. This really helps me focus on your likes, dislikes, patterns, strengths, and gaps.
   Tell me a little about your average day: What are you eating? SKIP THIS TABLE IF FILLING OUT A FOOD DIARY

Meal Part	**Foods Consumed**
Breakfast	
Snack	

Lunch
Snack
Dinner

a. What % of your food is home cooked? ____ Where else are you eating (restaurants, prepared foods section, etc? _____
b. Do you have times of the day when you are most hungry? _____
c. Do your weekday eating habits differ from your weekend? Better or worse? Please explain:_____
d. How often do you eat out, or pick up take-out during the week?_____ Weekends? _____
e. What foods would I always find in your cupboard?_____
_____
f. What foods would I always find in your refrigerator? _____
_____
g. Where do you shop? How often? When? _____
h. Do you enjoy cooking? Y / N If No, why not? _____
i. Do you enjoy grocery shopping? Y / N
j. Do you ever shop in the Health Food section of the store? Y / N
k. Do you read nutritional panels? Y / N
l. Circle all that apply when deciding what to buy:

1. Taste
2. Price
3. Nutrition
4. Ease of Preparation

2. Knowledge:
a. Have you read any nutritional books? Which ones?

b. Are you interested in reading other books to help you reach your goals?

3. a. I eat fresh fruit: ___ daily ____occasionally ____seldom

b. I eat fresh vegetables: ____daily ____occasionally ____seldom

c. The wheat, rice, and pasta I typically eat are: ____ refined, white ____ whole grain, coarse

d. The dairy products I typically eat are: ___full fat ____low fat ____ skim ___I don't typically eat dairy products

e. Do you eat soy products? If so, how many servings/week and what products?_____

f. The meats I typically eat are: ____high fat (prime beef, hamburgers) ____medium fat (lean red meat, chicken with skin) ____lean (fish, white meat chicken/turkey)___I don't eat meat

g. I eat fried foods, including fast foods: ___often ____occasionally ____seldom ____never

h. My intake of fats such as butter, margarine, salad dressing, and mayonnaise is: ____I seldom control my intake ____I occasionally watch my intake ___I always watch my intake

i. Do you feel your diet is deficient in some way?_____
Do you feel your diet is excessive in some way?_____

j. What are your 3 favorite foods in the following categories:

1. Favorite fruits _____
2. Favorite vegetables _____
3. Favorite meats / seafood _____
4. Favorite grains _____
5. Favorite dairy _____

6. Favorite snacks _____

Health Goals:

1. Is your health currently getting better, worse, or staying the same? How do you know?

2. What have you tried to improve your health (i.e. doctor visits, alternative treatments, other treatments, etc.)

3. Please list the 5 most stressful events in your life **past and present**, from most stressful to least stressful. Are any of these events continuing to impact your life?
   a.
   b.
   c.
   d.
   e.

4. How would you rate your stress level, on a scale of 1-10 (with 10 being the highest)? What are the main causes of stressors your life?

5. For our time together to be a **true win**, what do you want to accomplish over the course of our time together?

6. How long do you think it will take?

7. What is your present level of **commitment** to change the underlying causes of problem (s) which relate to your lifestyle from 1-10 (with 10 being 100%)?

8. What **obstacles** could prevent you from changing those lifestyle habits that are undermining your health?

9. Who will be willing to support you in your health goals?