

Health Quest Wellness Nutritional Questionnaire

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Ht. _____ Wt. _____ M F (please circle)

Birth Date _____ Usual Weight _____ Goal Weight _____

E-Mail _____ Impedance _____ (We will measure **this.**)

Have you ever participated in a nutrition counseling program that is based on real food and long term lifestyle changes? (not commercialized weight loss programs or a personal trainer) _____

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) _____

Of the Nutritional programs or diets tried did you achieve ANY success? How?

Describe your frustrations or failures of the past in trying to obtain your optimal body weight.

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 (lean mass increase) important? _____

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

PLEASE ANSWER THE QUESTIONS BELOW:

Have you ever had your metabolic rate measured?

How many hours of sleep do you get per night?

Do you consume Alcohol?? How many drinks per week?

Do you consume coffee, energy drinks or other caffeine drinks throughout the day?

Do you use Tobacco? How Often?

How often do you exercise?

Do you perform resistance or weight training?

How would you rate your flexibility?

Do you commute to work? How many miles or time is spent in traffic?

How much water do you consume daily?

How many meals do you eat per day?

Do you skip meals?

Do you eat meats? What kind? How Often?

Do you consistently add condiments to your meals? (Spreads, dressings, ketchup, Salts, etc)

Do you consume dairy or dairy products?

How many servings of fruit do you eat per day?

How many servings of vegetables do you eat per day?

How much bread/Grain do you consume per day?

Do you know the difference between whole grain and refined grain?

How often do you eat fast food?

When is the last time you had blood work done to check Cholesterol, fasting glucose, and triglycerides? (**Please Bring your most recent blood work to your first appointment.**)

Are you exposed to chemicals or pollution in your environment? (Work or Home) What are they?

Describe your daily activity at work and home?

Do you sit for extended periods of time? (Greater than 4 hours)

If you set your mind to a task you complete it?

Are you easily distracted?

Physician's Number _____
May we send your primary physician a summary of your results? _____

MEDICAL HISTORY (You and Family) 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	•	•
12) History of total Cholesterol greater than 200 mg/dl	•	•
13) Family history of coronary heart disease or other atherosclerotic Disease in parents or siblings before age 55	•	•
14) History of cigarette smoking	•	•
15) Do you take vitamins?	•	•
16) Are you allergic to soy?	•	•
17) Are you allergic to lactose / dairy products?		
18) Have you spine and nerve system evaluated in the past year?		
19) Are you taking any medications? If so, what? _____		

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

WOMEN ONLY:

- 20) Are you pregnant, lactating or anticipating becoming pregnant? _____
- 21.) Have you ever been diagnosed or told you are at risk for Osteoporosis?
- 22.) Women over 35, have you had a mammogram in the last 24 months?
- 23.) Do you get an annual Pap smear? Last exam date _____

MEN ONLY:

- 24.) Men over 40. Have you had a prostate screening in the past 24 months?

***FOOD LOG* (5 day- Minimum) Using a Journal please include everything you consume including Meals, Snacks, Beverages & Estimate Portion Sizes.**

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 _____