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Nutritional Analysis

Date: _____

Blood Type: _____

Name: _____

Address: _____

Phone: (home) _____ (work) _____ (cell) _____

Email address: _____

Last physical exam: _____ performed by whom?: _____

Health concerns/ issues: _____

Birthday: _____

Age: _____ weight: _____ height: _____ M/F: _____

Desired weight: _____ wt to gain: _____ wt to lose: _____ Date to achieve desired weight? _____

Reasons for wanting to lose/ gain weight: _____

Reasons for seeing a nutritionist: _____

How did you hear about me? friend (_____) magazine ad (LSM PhillyFit)
website other (_____)

Do you smoke or use tobacco products? _____ Does anyone smoke in your home? _____

If yes, how many packs per day? You _____ someone else _____

Do you use over the counter drugs? Yes _____ No _____

If yes, what do you take? _____ for what symptom? _____

how much, how often? _____

Do you take prescription drugs? Yes _____ No _____

If yes, what do you take? _____ for what symptom? _____

How much, how often? _____

How much water do you drink per day? _____ glasses

Is it filtered or purified? Please specify: _____

How many cups of coffee _____, soda _____, or black tea _____ do you drink daily?

How many cups of diet soda _____, diet tea _____ or diet drinks _____ do you drink daily?

Which artificial sweeteners are you most familiar with? (check those you know; mark with an "X" if you use that one)

Aspartame Saccharin Sucralose Equal
 Acesulfame-K NutraSweet Splenda other _____

Do you take nutritional supplements (vitamins)? Yes _____ No _____

If yes, please list what you take. Please include brand, type, quantity taken per day:

How would you rate your knowledge of nutrition and nutritional supplements?

excellent fairly good poor know nothing



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Do you exercise? Yes ___ No ___
 If yes, how often? _____ what kind of exercise? _____
 How long? _____ what intensity? _____
 What time of day? _____ before meal? Y__N__ after meal? Y__ N__

What is your occupation? _____

How many hours on average do you work per week? _____

How would you describe your job?

___ physical ___ mental ___ stressful ___ rewarding
 ___ easy-going ___ secure ___ non-secure ___ exhausting
 ___ relaxing ___ demanding ___ other _____

What do you do when you come back from work? Please include hobbies, etc:

Do you drink alcohol? Yes ___ No ___

If yes, how much and how often? _____

___ beer ___ wine ___ spirits ___ mixed drinks

Do you have food allergies? Yes ___ No ___ Not sure ___

If yes, to what? _____

Do you have food cravings? Yes ___ No ___

If yes, what do you crave? (chocolate, salty snacks, sweets, cookies, etc)

Do you avoid certain foods? Yes ___ No ___

If yes, what do you avoid and why? _____

Do you experience the following on a regular basis (mark as D-daily, W-weekly, M-monthly, etc) ?

___ acid reflux ___ nausea ___ IBS ___ diarrhea ___ fatigue
 ___ constipation ___ headaches ___ migraines ___ back pain ___ pain
 ___ indigestion ___ fatigue/ tired ___ cannot sleep ___ cannot stay asleep ___ heartburn
 ___ sinus congestion ___ runny nose ___ post nasal drip ___ depression ___ anxiety
 ___ other (please list: _____) ___ stress ___ other _____ ___ mood swings

For females only: Do you have PMS? Yes ___ No ___

If yes, what symptoms?: please check all that apply

___ bloating/ water retention ___ chocolate cravings ___ anxiety

___ moodiness ___ tender breasts ___ other

___ hot flashes ___ menopause – describe _____

Is your period regular? Yes ___ No ___ Not applicable ___

If no, what makes it irregular? (eg. irregular duration, irregular cycle, some heavy flow, some light, etc) _____



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Please circle the foods you like.
 Mark the ones you 'hate' with a line thru that item.

<u>Fruits</u>	<u>Vegetables</u>	<u>Proteins</u>	<u>Beans/ legumes</u>	<u>Other</u>
Apple	Carrot	Lamb	Black beans	Basil
Banana	Eggplant	Beef	Lima beans	Onion
Cantaloupe	Iceburg lettuce	Venison	Kidney beans	Leek
Pear	Romaine lettuce	Salmon	Cannelini beans	Garlic
Pineapple	Peas	Swordfish	Soybeans/ edamame	Parsley
Cranberry	Green beans	Lobster	Peanut	Cilantro
Blueberry	Potato	Scallops	Almond	Chives
Honeydew melon	Tomato	Shrimp	Soybeans, dry, roasted	Oregano
Grapes, red	Beet	Turkey	Cashews	
Grapes, green	Sweet potato	Chicken	Tofu	<u>Dairy</u>
Orange	Radish	Liver, calf	Pinto beans	Milk
Lemon	Radicchio	Liver, chicken	Baked beans	Yogurt
Lime	Endive	White eggs	Walnuts	Sour cream
Kiwi	Broccoli	Brown eggs	<u>Grains</u>	Butter
Mango	Sugar snap peas	Egg whites	Wheat	Cheese
Papaya	Cauliflower	Lamb	Oats	Soy milk
Strawberry	Turnip	Tuna	Quinoa	Rice milk
Raspberry	Parsley	Other fish	Corn grits	Almond milk
Apricot	Cilantro		Bread, white	Goat's cheese
Plum	Zucchini		Bread, multi-grain	Sheep cheese
Prune	Yellow squash		Corn chips	Goat yogurt
Peach	Pumpkin squash		Pumpernickel	
Pluot	Cabbage, red		Rice, white	
Plantain	Cabbage, white		Rice, brown or wild	
			Amaranth	
			Spelt	

Please list any other foods which you do not like at all (and the reasons why):



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For the following section, please write down as accurately as possible, everything that you have eaten and drank for the past 2-4 days. Please be as specific as possible. Also include coffee (specify if caf/decaf), alcoholic beverages, soda (what kind or if diet), candy bars, etc and estimate the serving sizes (1 cup, 8 oz liquid, etc). If you drink milk, please indicate if whole, 2% or skim, etc. Please explain as well as possible how the food was prepared, eg. 1 chicken breast – fried, baked or broiled? With skin? Breaded? Marinated? In what? What type of oil was used, etc.

Day 1 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
 How did you sleep? ___ soundly _____ tossed and turned _____ out like a light
 Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
 Did you exercise? Yes ___ No ___ What? _____
 How long? _____ What time? _____
 Did you have a bowel movement? Yes ___ No ___ how many times today? _____
 Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
 Symptoms: _____

Breakfast: (what time? _____)

Snacks: (what time? _____)

Lunch: (what time? _____)

Snacks: (what time? _____)

Dinner: (what time? _____)

Is this your usual way of eating? Yes ___ No ___

If no, what made it different? _____



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Day 2 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes ___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)

Snacks: (what time? _____)

Lunch: (what time? _____)

Snacks: (what time? _____)

Dinner: (what time? _____)

Is this your usual way of eating? Yes ___ No ___

If no, what made it different? _____



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Day 3 – day of week: _____

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly ___ tossed and turned ___ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes ___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)

Snacks: (what time? _____)

Lunch: (what time? _____)

Snacks: (what time? _____)

Dinner: (what time? _____)

Is this your usual way of eating? Yes ___ No ___

If no, what made it different? _____



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Day 4– day of week:

When did you go to sleep? _____ When did you wake up? _____
How did you sleep? ___ soundly _____ tossed and turned _____ out like a light
Did you have trouble falling asleep? _____ Did you have trouble staying asleep? _____
Did you exercise? Yes ___ No ___ What? _____
How long? _____ What time? _____
Did you have a bowel movement? Yes ___ No ___ how many times today? _____
Do you take fiber supplements? Yes ___ No ___ if yes, which one _____
Symptoms: _____

Breakfast: (what time? _____)

Snacks: (what time? _____)

Lunch: (what time? _____)

Snacks: (what time? _____)

Dinner: (what time? _____)

Is this your usual way of eating? Yes ___ No ___

If no, what made it different? _____

Additional comments: _____

Thank you for your participation.

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