RAIN CITY NUTRITION

Initial Visit Questionnaire

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Name:_____

A. What are your most important goals/ concerns/ questions to address today?

1)_____

2)_____

3)_____

B. Please list typical weekly exercise/activity including type and amount

_____

_____

C. Current Height _____Current weight (if known) _____

D. In the past six months, my weight has increased/decreased by _____ lbs.

E. Have you ever been diagnosed with an eating disorder or are you concerned that you may have an eating disorder? _____ YES _____NO

F. On a typical day would you say your appetite is _____ Poor _____ Fair _____ Good

G. If you are currently following a special diet, please list or describe:

_____

_____

H. Please list any food allergies or intolerances you have:

_____

_____

_____

I. Please list all vitamin, mineral, and herbal supplements you are currently taking:

_____

_____

_____

J. Please indicate your typical alcohol consumption: _____ drinks/week

K. How often do you eat out (including meals, snacks, coffee drinks, etc…)

_____ meals / _____

L. Who does most of the grocery shopping for your house?

_____

_____

M. Who does most of the food preparation for your house?

_____

_____

N. Please add any additional information you would like me to be aware of:

_____

_____

_____

_____

_____

_____

_____

_____