BASIC NUTRITION QUESTIONNAIRE

Name: _____ Date: _____

Have you ever been told you have High Cholesterol and Triglycerides? YES/NO

Have you ever been diagnosed with High Blood Pressure? YES/NO

Have you ever been diagnosed as a Diabetic? YES/NO

Have you ever been diagnosed as Pre-Diabetic or Metabolic Syndrome? YES/NO

How many days a week do you skip a meal (3 meals per day)? _____

How many fast food, refined food, or pre-prepared meals do you eat per week? Circle one:
(1-3) (4-6) (7+)

How many servings of fruit do you eat per day? Circle one: (0-1) (2-3) (4-5)

Do you regularly drink 1 or more per day of the following (circle all that apply):

Soda Diet Drinks Coffee Juice Milk Alcohol Energy Drinks

Do you need caffeine to wake up in the morning? YES/NO

How many servings of refined sugar do you eat per day? (candy, cookies, cake, etc.) (0-1) (2-3) (4-5)

Do you have any energy crashes after you eat in the afternoon? YES/NO

Please list all the nutritional supplements/vitamins you take regularly. Use back of sheet if needed. (staff can photocopy a list if you have one):

Supplement Name/Type	Frequency	Brand/Where purchased
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____