

Nutritional Counseling

Name _____ Age _____ Date _____

1. How many hours of sleep do you get a night? _____

What time do you turn the lights off? _____

2. Current medications and amounts: _____

3. How many servings of fruits & vegetables do you daily eat? _____

4. How many soft drinks do you drink a day? _____

5. How many times do you eat out a week? _____

6. How many glasses of water do you drink a day? _____

7. Do you avoid foods that contain high fructose corn syrup? _____

8. Do you avoid foods with preservatives? _____

9. Do you shop for any organic products? _____

If so, which items? _____

10. Type of exercise: _____

How often? _____ How long? _____

11. What supplements do you take?

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Date of Birth: _____