Health/Nutrition Questionnaire

NAME: ______________________________ DATE: ____________

1) Do you take any medication? If yes, please list: ______________________________

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2) Do you have any food allergies? If yes, please list: ______________________________

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3) What are your favorite foods? ______________________________

4) What are your least favorite foods? ______________________________

5) Do you eat breakfast? ______________________________

6) How many times do you usually eat a day? ______________________________

7) Do you take supplements? If yes, please list: ______________________________

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8) What is your Blood type? ______________________________

9) Do you know how many calories a day do you eat? ______________________________

10) What is your goal? Why? ______________________________

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