HOLY CROSS HEALTH
A Member of Trinity Health

Nutrition Pre-Consultation Questionnaire

First Name: _____ Last Name: _____ DOB: ___/___/___

Please answer each question as thoroughly as possible prior to your first consultation.

1. I would like nutrition counseling because:
   _____
   _____

2. My goals for these sessions are:
   _____
   _____
   _____
   _____

3. My past and current medical conditions include (i.e. diabetes, high cholesterol, etc.):
   _____ _____
   _____ _____
   _____ _____
   _____ _____

4. I take the following medications (please include all):
   _____ _____
   _____ _____
   _____ _____
   _____ _____

5. I take the following supplements (please include all):
   _____ _____
   _____ _____
   _____ _____
   _____ _____

6. I would like to lose weight ☐ True ☐ False
7. I have tried to lose weight in the past ☐ True ☐ False (if true, explain how)
   _____
   _____

8. I exercise or participate in physical activity. ☐ True ☐ False (if true, please provide details)
   _____
   _____

9. Do you have any food allergies/intolerances/religious observances related to food? ☐ Yes ☐ No
   If so, what are they? _____
   _____

First Name: _____ Last Name: _____ DOB: ___/___/___

Please include a typical day's meal plan. Please include the times at which you eat. If known, include portion sizes, condiments/dressings, desserts/snacks, and beverages.

Date and Time	**Food/Drink** (Please be specific, include details such as how food was cooked and sauces, seasonings, and dressings added)	**Amount** (i.e. 1 cup, 2 Tbsp, etc.)