Client ID -

Sattvika Nutrition LLC® Client Nutrition History

Client Name

First Name Middle Initial Last Name

Gender *Male / Female* Marital Status *Single / Divorced / Married*

Occupation

Education

Age Height ft. inches

Weight lbs. or kg.

Your Weight Goals *Maintain / Gain / Reduce Weight*

Have you tried to gain or reduce weight in the past?

How often do you exercise?

What is the duration of your exercise?

What type of exercises or physical activity do you enjoy?

Name of your Physician

Physician Contact Information

Medical History

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Family Medical History

Are you taking any medications? *Yes / No*

Describe

Do you smoke? *Yes / No*

Do you get a good night's rest? *Yes / No*

How many hours do you sleep?

How often do you eat healthy, well balanced nutritious meals?

Everyday / Weekdays / Weekends / Vacation

Do you eat breakfast everyday? *Yes / No*

Do you eat lunch everyday? *Yes / No*

Do you eat dinner everyday? *Yes / No*

How often do you skip meals or fast? *Never / Rare / Frequently / Religious occasion*

Describe

How often do you eat healthy snacks? *0 / 1 / 2 / 3 / 4 or more per day*

What is your favorite snack?

Do you eat fresh fruit everyday? *Yes / No*

Do you feel hungry before eating meals or snacks? *Yes / No*

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Do you eat when you are bored? *Yes / No*

Do you eat while watching tv? *Yes / No*

How often do you eat out?

Do you take vitamins / supplements / herbs / botanicals? *Yes / No*

Describe

Do you drink alcohol? *Yes / No*

Describe

Are you on a diet? *Yes / No*

Describe your food restrictions. For example, vegetarian, Jain vegetarian, vegan, kosher, halal, ….

Do you have access to healthy food?

List all the vegetables you eat regularly

List all the fruits you eat regularly

Do you have any food allergies? *Yes / No*

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Describe

What are your nutrition goals?

Describe

Signature Date