FITNESS RANGERS

Scott Estrada, CPT & CNC Nutrition Coach
(P) 916.541.0813

Nutrition/Lifestyle Questionnaire

Please answer to following questions as completely as possible. This information is needed in order to make an accurate assessment of you health and nutrition goals.

THE BASICS

Name:_____

Mailing Address:_____

Phone #'s:_____

Email:_____

Height: _____ **Weight:**_____ **Age/D.O.B.:**_____

Blood Type:_____ **Food Allergies:**_____

Medications:_____

Supplements:_____

If weight loss is a goal, how much:_____ **Why:**_____

What are your fitness goals:_____

How often do you exercise:_____

Are you strength training, how often:_____

THE LIFESTYLE

Foods you love to eat:	Foods you hate to eat:

Cravings you get (food & drink):	What time of day:

Of the following, how much do you consume daily?	
Water	
Coffee	
Sodas	
Alcohol	

What do you eat in a typical day (food & drink)?					
Breakfast	Snacks	Lunch	Snacks	Dinner	Snacks

Do any of the following pertain to you?	YES	NO
Do you eat a low fat diet?		
Do you yo-yo diet?		
Do you skip meals?		
Do eat carbohydrates in excess?		
Do you use saccharin, aspartame, margarine or any other synthetic, refined and processed foods?		
Do you drink soft drinks or juices with high fructose corn syrup?		
Do you use tobacco?		
Do you use stimulants?		
Do you feel stress or anxiety?		
Are you sedentary?		
Do you take thyroid hormone medication?		
Do you take steroids?		
Do you take over the counter cold meds?		
Do you use diet pills?		
Do you have trouble sleeping?		

Are there any other symptoms you are experiencing?_____

_____

Of all your body functions, where do you feel most imbalanced (i.e. digestion, breathing, circulation, elimination, mental/brain, hormonal, etc.)?

_____