SLO Nutrition
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General Health & Nutrition

Age:_____ **Height:** _____ **Weight:**_____ **Usual Weight:**_____

Goal Weight:_____ **Blood Type**:_____

Health & Medical Conditions:
Circle any that apply

High Cholesterol	Anemia	Hypoglycemia
Diabetes	Cancer	Celiac disease
High Blood pressure	Liver disease	Overweight
Kidney disease	Thyroid disease	Food allergies

Other_____

Current Medications:

Current Supplements:

Current Symptoms:
Circle any that apply

Gas/bloating	Fatigue	Food cravings
Constipation	Brain fog	Irritability
Diarrhea	Joint pain	Poor sleep
GERD/reflux	Unexplained weight gain	

Other_____

What are your health goals?

Lifestyle & Professional Activity Level:
Circle the activity level that applies

Sedentary Moderately active Active Very active

Explain the type of exercise you perform on average during a 7-day period.

Activity 1:_____

Duration:_____ **Frequency:**_____

Activity 2:_____

Duration:_____ **Frequency:**_____

Activity 3:_____

Duration:_____ **Frequency:** _____

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

Do you feel rested and refreshed when you wake up?_____

Do you drink alcohol?_____ **How many drinks/week?**_____

Do you smoke?_____ **How much?**_____

Do you grocery shop?_____ **How often?**_____

Do you cook?_____ **How often do you dine out?**_____