Nutrition Analysis Guide

First name:_____

Age:_____ Sex:_____ Weight:_____ Height:_____ # of children:_____

Desired weight:_____ Health concerns:_____

Please write down everything you eat and drink for the next three days as accurately as possible. Also include coffee, alcoholic beverages, soda, candy bars, etc., and estimated serving sizes whenever possible. Try to be specific. For example, instead of writing "1 cup of milk," specify if the milk was low fat or 2%. Explain in detail how the food was prepared. For example, instead of writing 1 chicken breast, describe whether the chicken was fried, baked, or grilled, what kind of oil was used, if it was breaded, and so forth. Please leave the Consultant's Comments areas blank.

Day 1:

Breakfast:

Lunch:

Dinner:

Snacks:

Day 2:

Breakfast:

Lunch:

Dinner:

Snacks:

_____

_____

_____

Day 3:

Breakfast:

_____

Lunch:

_____

_____

_____

_____

_____

Dinner:

_____

_____

_____

_____

_____

Snacks:

_____

_____

_____

_____

Is the above an accurate representation of your overall diet? Yes ( ) No ( )

If “no,” please explain what you do differently:

_____

_____

_____

_____

Consultant's Comments:

_____

_____

_____

What time do you eat your last meal?_____

Consultant's Comments:

_____

_____

_____

Do you eat breakfast on a regular basis? Yes ( ) No ( )

Consultant's Comments:

_____

_____

_____

Do you cook at home most of the time? ( ) Or eat out most of the time? ( )

Consultant's Comments:

_____

_____

_____

Answer the following questions to the best of your ability. If there's something you're unsure about, leave it blank and discuss it with your Nutritional Consultant. Serving size generally equals one cup or 3 ½ ounces. These figures don't have to be exact, just give the most accurate guess you can.

1. How many glasses of purified water do you drink per day?_____

Consultant's Comments:

_____

_____

_____

2. How many servings of fresh fruits/vegetables do you eat per day?

_____

Consultant's Comments:

_____

_____

_____

3. How many servings of low fat protein (beans, fish, and skinless chicken breast) do you eat per day?

_____

Consultant's Comments:

_____

_____

_____

4. How many servings of complex carbohydrates (bran, whole grains, starchy vegetables) do you eat per day?_____

Consultant's Comments:

_____

_____

_____

5. Approximately what percentage of fat makes up your total caloric intake?

_____

Consultant's Comments:

_____

6. Do you drink fresh fruit/vegetable juices every day?

_____

Consultant's Comments

_____

_____

_____

7. Do you eat organic fruits and vegetables every day?

_____

Consultant's Comments:

_____

_____

_____

8. How many cups of coffee, soda, or black tea do you drink per day?

_____

Consultant's Comments:

_____

_____

_____

9. How many refined sugar items (candy bars, donuts, cakes,etc.) do you eat per day?

_____

How many containing artificial sweeteners (Sweet-N-Low. Splenda, Equal, etc.)?_____

Consultant's Comments:

_____

_____

_____

10. How many fast food items (hamburgers, hot dogs, frozen dinners, canned foods, French fries, etc.)

do you eat per day?_____

Consultant's Comments

_____

_____

_____

11. How many servings of bread, pasta and other processed carbohydrates do you eat per day?

Consultant's Comment's

_____

_____

12. How many servings of dairy do you eat per day?

_____

Consultant's Comments:

_____

_____

_____

13. How many servings of processed or smoked meat (salami, ham, hot dogs, sausages, boloney, etc.) do you eat per day?

_____

Consultant's Comments:

_____

_____

_____

14. Do you smoke or use tobacco products? Yes ( ) No ( ) If "yes", how much?

Consultant's Comments:

_____

_____

15. Do you take over-the-counter

drugs?_____

What kinds of over-the counter drugs?

_____

_____

_____

Consultant's Comments:

_____

_____

_____

16. Do you take any nutritional supplements (vitamins, minerals, digestive enzymes, amino acids, herbs, etc.) on a daily basis? Yes ( ) No ( ) If "yes", please describe in detail, including doses:

_____

_____

_____

Consultant's Comments:

_____

_____

_____

17. How would you rate your knowledge of nutritional supplements?

Excellent ( ) Fairly good ( ) Poor ( )

Consultant's Comments:

_____

_____

_____

18. How many days a week do you exercise for a minimum of 30 minutes?

Consultant's Comments:

_____

19. What is your occupation?_____

How would you describe your job (mark as many as applies): Physical ( ) Mental ( ) Stressful ( )

Easy-going ( ) Secure ( ) Non-secure ( ) Exhausting ( ) Relaxing ( )

Consultant's Comments:

_____

20. How many hours do you work in an average week?_____

Consultant's Comments:

_____

_____

21. Does anyone smoke in your home? Yes ( ) No ( )

Consultant's Comments:

_____

_____

22. Mark any potentially harmful elements you regularly come in contact with at home or at work:

Humidity ( ) Mildew ( ) Poor ventilation ( ) Air conditioning ( ) Carpet (over 4 years old) ( )

High traffic road nearby ( ) Smog ( ) Fluorescent lighting ( ) Strong cleaners ( )

Insect repellents ( ) Lawn and garden chemicals ( )

Consultants Comments:

_____

_____

23. Do you suffer from Candida albicans? Yes ( ) No ( ) Not Sure ( )

Consultant's Comments: _____

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24. Are you currently breastfeeding or pregnant? Yes ( ) No ( )

Consultant's Comments: _____

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25. When was your last physical exam with a primary physician?_____

Consultant's Comments: _____

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26. How many hours do you sleep/night?

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27. Do you have a hard time falling asleep? Yes ( ) No ( )

28. Do you wake up frequently through the night? Yes ( ) No ( )

29. Have you been told that your Vitamin D levels are low? Yes ( ) No ( )

30. Do you know what the Vitamin D numerical level is?

_____

31. What is your average blood pressure?_____

32. What is your cholesterol level?_____

33. On a scale from 0 to 10, how would you rate your average stress level? 0 is no stress and 10 is out of control stress_____

34. Describe your support system…family, friends, church, groups.

_____