ANGE YATES
NUTRITIONIST

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Please click and complete the following information:

Title: Select **Surname:** _____

First Name(s): _____

Date of Birth: _____ **Age**: Select

Address:

_____

_____

Mobile: _____ **Home:** _____ **Work:** _____

Email: Someone@example.com **Occupation**: _____

Hobbies: _____

Height: ___ cm **Current Weight**: ___ kg

Ethnicity: _____

What is your number one nutrition goal: _____

When would you like to achieve this by: _____

How did you hear about my services: _____

ADDITIONAL GOALS (please select option(s) applicable to you)

☐ Improve Strength ☐ Improve muscle tone

☐ Reduce stress ☐ Rehabilitate or prevent injury

☐ Gain muscle/weight ☐ Increase energy

☐ Improve sport performance ☐ Combat an illness

☐ Improve eating habits ☐ Weight loss

☐ Improve cardio fitness ☐ Improve sleep

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FITNESS HISTORY

Are you presently involved in a regular exercise programme? (If yes please list):

_____

FREQUENCY: _____ **DURATION:** _____

MEDICAL HISTORY

Do you have or have had you had any of the following? (please circle option(s) applicable to you)

☐ Type 1 Diabetes
☐ Type 2 Diabetes
☐ Anaemia
☐ Eating disorder
☐ Stroke
☐ Polycystic ovaries
☐ Cancer, cysts, tumour
☐ Blood disease
☐ Hormonal imbalances
☐ Anxiety or depression
☐ Coronary disease
☐ Allergies
☐ Stomach or intestinal problems
☐ High or low blood pressure
☐ Thyroid issues
☐ Immune disorder

If you have ticked yes to any of the above please give details:

_____

Do you have any other medical conditions?

_____

Are you currently taking any medications or supplements? If yes, please give details:

_____

Are you currently pregnant or breastfeeding? Yes/No

Have any blood relatives ever had any of the following? (please select options(s) applicable to you)

☐ Sudden death before 50
☐ Blood diseases (anaemia, leukaemia etc)
☐ High blood pressure
☐ Epilepsy
☐ Heart disease
☐ Cancer, tumour, cyst
☐ Diabetes
☐ Stroke

How would you describe your sleep?

_____

HEALTH AND DIET HISTORY

Do you currently smoke or have you ever smoked? Yes/No

Do you drink alcohol? Yes/No If yes, how much and how often?

Yes/No _____

Do you drink coffee or cola's that contain caffeine? Yes/No If yes, how much and how often?

Yes/No _____

Do you have any food intolerances or are you vegetarian, vegan or follow any particular eating regime, and are there any foods you refuse to eat?

_____

_____

How do you consider your current weight? (please select option applicable to you)

☐ Overweight ☐ Ideal weight ☐ Underweight

If your goal is to lose body fat, do you feel you store body fat in one body part more than others?

Yes/No, **where?** _____

In the last 5 years

a. What is the most you have weighed? When? _____

b. What is the least you have weighed? When? _____

What other weight loss techniques have you tried? Please give details:

_____

_____

How are your energy levels? (please select option applicable to you)

☐ High ☐ Moderate ☐ Low

How would you describe your nutrition habits? (please select option applicable to you)

☐ Good ☐Fair ☐ Poor

Are there any other comments you would like to add regarding your health?

_____

_____

I do hereby state that I have, to the best of my knowledge and belief, given a correct and accurate medical history report.

Signature: _____ Date:_____

Full name:_____

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FOOD DIARY

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Please record quantities, times and include all teas/coffees/water	DAY 1 Select Day	DAY 2 Select Day	DAY 3 Select Day
BREAKFAST Record Time Here			
SNACKS Record Time Here			
LUNCH Record Time Here			
SNACKS Record Time Here			
DINNER Record Time here			
SNACKS Record Time Here			

Is this a usual 3 days eating for you? Yes/No

Do you regularly (daily) eat any of the following? (please select option(s) applicable to you)

☐ Desserts ☐ Fried Foods ☐ Fast Food

Do you regularly use any of the following? (please circle option(s) applicable to you)

☐Butter ☐ Sugar ☐ Sweeteners ☐ Salt

Do you have any other comments regarding your usual food habits?

_____

_____

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