

Cardin Center for Wellness

9159 W 133rd Street Overland Park, Kansas 66213

www.cardinwellness.com 913-239-8501

Nutritional Questionnaire

Date: _____

This is Confidential Information

Name _____

Address _____ City _____ Zip _____

Home Phone _____ Ht. _____ Wt. _____ M F (please circle)

Birth Date _____ Usual Weight _____ Goal Weight _____

E-Mail _____ Impedance _____ (We will measure this.)

Are you interested in a Complimentary Nutritional Consultation? _____

Are you interested in learning more about a nutrition-counseling program? _____

Have you ever participated in a **nutrition counseling program that is based on real food and long term lifestyle changes?** (not commercialized weight loss programs or a personal trainer) _____

Most Important Reason(s) for Considering Nutrition Counseling (start with most important)

What Nutritional Programs or Diets Have You Tried In The Past? (if any) _____

ANSWER 1 to 10. 1 = LOW IMPORTANT 5 = MEDIUM IMPORTANT 10 = VERY IMPORTANT

Is nutrition counseling for **cancer, heart disease, and disease prevention** important?

Is nutrition counseling for **weight management (reduce body fat & increase muscle)** important?

Is nutrition counseling for **weight gain (lean mass increase)** important? _____

Is nutrition counseling to **have more energy** and better workouts? _____

How many **pounds weight loss or gain** would you prefer **each week or month** (please circle)?
_____ lbs

What is a realistic Exercise Program For You to Complete Weekly?

LIST AT LEAST ONE PRIMARY EXERCISE (S):

Day of Week

1. _____ **MINUTES:** _____

2. _____ **MINUTES:** _____

3. _____ **MINUTES:** _____

Primary Physician's Name _____

Physician's Number _____

May we send your primary physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency: _____

Name _____

Relationship _____ Phone (____) _____ - _____

MEDICAL HISTORY Do you now, or have you had in the past:

NO

YES

- 1) History of heart problems, recurring chest pain, heart murmur, or stroke
- 2) Diagnosis of Hypertension or take medicine for same
- 3) Diabetes Mellitus
- 4) Asthma, breathing or lung problems
- 5) Cancer (other than skin)
- 6) Seizures, seizure medication, neurological problems or severe dizziness
- 7) Gallbladder disease or intestinal problems
- 8) Back problem, joint or muscle disorder still affecting you
- 9) Recent surgery (last 12 months)
- 10) Hernia or any condition that may be aggravated by lifting weights
- 11) Physician's advice not to exercise

WOMEN ONLY:

12) Are you pregnant, lactating or anticipating becoming pregnant?

If your answer is YES to any question above, give *brief* explanation: _____

- 13) History of total Cholesterol greater than 200 mg/dl
- 14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55
- 15) History of cigarette smoking
- 16) Do you take vitamins?
- 17) Are you allergic to soy?
- 18) Are you allergic to lactose / dairy products?

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program or taking any supplements. I take full responsibility for my participation in any of these programs for any claims for injuries or illness that may result from my participation in any of their programs.

Signature

Date

Witness

Date

