CLIENT QUESTIONNAIRE

First Name	Surname
Address	Occupation
Tel No (Home)	Email
Tel No (Mobile)	Children Y/N
DOB	GP
Height (cm)	Weight (kg)
Body Mass Index	

Current medical conditions
Medication details
Past medical history
Please rate your physical activity Scale of 1 to 7 (1 = none and 7 daily 30 mins or more)
Do you have a goal or aim for the future you are hoping to achieve?

Who shops?	Who cooks?

Diet History				
Cooking Methods – please tick	Food Consumption – please enter how many times a week you eat the following:-			
Frying Boiling Microwaving Grilling Deep frying Stir fry Steaming Roasting Baking Poaching Braising	Meat		Biscuits	
	Fish		Cake & Pudding	
	Cheese		Sugar	
	Eggs		Butter/Marg	
	Milk & Yoghurt		Alcohol	
	Fruit		Soft drinks	
	Vegetables		Preserves	
	Potato		Sweets/Chocs	
	Bread		Nuts & Crisps	
	Cereal		Takeaway	
	Pulses/Quorn Soya		Sauce/Mayo	

Please use this box to fill in any further information you feel may be relevant to assist in the consultation i.e. sleep patterns, alcohol intake, shift work, smoker, depression, bowel concerns, family issues……