

# CLIENT QUESTIONNAIRE

Name: \_\_\_\_\_ DOB (mm/dd/yy): \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: (H) \_\_\_\_\_

City: \_\_\_\_\_ (W) \_\_\_\_\_

Postal Code: \_\_\_\_\_ (cell) \_\_\_\_\_

Email : \_\_\_\_\_ Where do you work? \_\_\_\_\_

Doctor: \_\_\_\_\_ Dr. Phone & fax: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

What goals do you hope to achieve through dietary counseling? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Height: \_\_\_\_\_ Present weight: \_\_\_\_\_ Your usual weight: \_\_\_\_\_ Highest weight ever: \_\_\_\_\_

Lowest adult weight: \_\_\_\_\_ What would be a realistic weight for you , today? \_\_\_\_\_

Were you an average weight at 10 years old? No  Yes

Have you lost weight in the past No  Yes

If yes, what worked for you? \_\_\_\_\_

\_\_\_\_\_

Who lives with you? \_\_\_\_\_

Who does the cooking at home? \_\_\_\_\_ Who does the grocery shopping? \_\_\_\_\_

What is your favourite non-alcoholic beverage? \_\_\_\_\_ How much do you drink? \_\_\_\_\_

## Do You:

Drink alcohol No  Yes  What kind? \_\_\_\_\_ How often? \_\_\_\_\_

Smoke No  Yes  # Per day? \_\_\_\_\_

Drink water No  Yes  # Per day? \_\_\_\_\_

Sleep well No  Yes  Bed time? \_\_\_\_\_ Hours? \_\_\_\_\_

Eat in evening No  Yes  If yes, what? \_\_\_\_\_

Food allergy/intol. No  Yes  If yes, what? \_\_\_\_\_

Have pets No  Yes  What kind? \_\_\_\_\_ How many? \_\_\_\_\_

What time of day do you usually **over eat**? \_\_\_\_\_

What is the food(s) that you choose to overeat? \_\_\_\_\_

What is your favorite food? \_\_\_\_\_ Do you keep this food in the house? No  Yes

TRAINWITHMIKE

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[www.trainwithmike.ca](http://www.trainwithmike.ca)

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Do you have a sweet tooth or salty tooth? \_\_\_\_\_ What is your favorite dessert ? \_\_\_\_\_

**Please write down what you ate and drank YESTERDAY:**

**Eating times:**      **Breakfast:** \_\_\_\_\_      **Lunch:** \_\_\_\_\_      **Supper:** \_\_\_\_\_

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Supper: \_\_\_\_\_

Do you snack? Yes  No

If yes, Time: \_\_\_\_\_ What: \_\_\_\_\_ Time: \_\_\_\_\_ What: \_\_\_\_\_

More snacking? \_\_\_\_\_

How many times a week do you eat out?

Breakfast: \_\_\_\_\_ Restaurant: \_\_\_\_\_

Lunch: \_\_\_\_\_ Restaurant: \_\_\_\_\_

Dinner: \_\_\_\_\_ Restaurant: \_\_\_\_\_

What is your favorite restaurant? \_\_\_\_\_

**Do you exercise**      No  Yes       If no, why not? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

What are your hobbies? \_\_\_\_\_

How much screen time do you watch per day? TV, computer, electronic device, etc.

At work \_\_\_\_\_ hrs; at home \_\_\_\_\_ hrs

**If you take medication and/or supplements, please list here:**

Medications/Supplements	Dosage	Frequency

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## FILLED OUT BY Nutritionist: Progress Chart

Weight	Waist Measurement	Hip Measurement	Chest Measurement	Date

**Methods of Payment: Cash or Cheque (made out to TRAINWITHMIKE)**  
**CANCELLATION POLICY : 24 hour notice is required; if not, a fee of 70% will be applied.**

**Waiver & Disclaimer: The information you are receiving is for you personally and not to be transferred;  
legal responsibility is waived.**

I consent to release the dietary information to L'Équipe TRAINWITHMIKE health and wellness specialists.

Yes, I agree : \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date