LINDSAY Jang, RD

Name: _____ Phone: _____

Age _____ Height _____ Weight_____ Referred by _____

Add me to the mailing list for a free 3-day meal plan, recipes and tips. ☐ Yes ☐ No

Has your weigh changed recently? ☐ Gain ☐ Loss ☐ No Change

What is your primary nutrition concern? _____

What is your primary goal? (what would you like to see or get while working together?)

_____

Medical History

_____

_____

Medications (including nutritional supplements)

_____

_____

Allergies/Intolerances _____

Do you eat : ☐ Quickly ☐Moderately ☐Slowly

Which meals do you eat daily? ☐ Breakfast ☐ Lunch ☐ Dinner

Do you snack? ☐ Yes ☐ No

If so what do you snack on? _____

How many restaurant meals do you eat each week (includes fast food, take-out, dine-in, breakfast, lunch and dinner)? _____

Do you take any supplements? If so, please list _____

Do you drink alcohol? If so, how many drinks per week? _____

What do you drink on a daily basis? How many cups (8oz.) per day?

Water _____ Pop _____ Juice _____ Coffee _____

Tea _____ Milk or milk alternatives _____ Sports Drinks _____

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