Meal Planning Questionnaire

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Client Name: _____ Weight: _____ Height: _____

Date: _____

Do you consider yourself to be one of the following:
___ Vegetarian ___Pescatarian ___Vegan

List any specific diets used in the past and its result (e.g. Paleo – Weight Loss)	
1.	2.
3.	4.

FOOD ALLERGY
___ Dairy ___ Soy ___ Eggs ___ Peanuts ___ Tree nuts
___ Fish ___Shellfish ___ Sesame ___ Corn
___ Wheat(do not check this for celiac disease or gluten sensitivity, only wheat allergy)
Other, please list: _____
_____

FOOD INTOLERANCE
___ Gluten (celiac disease or non-celiac gluten sensitivity, includes wheat, barley, oats, rye)
___Lactose ___Fructose ___Sulfites ___Histamines ___Nitrites ___Fructans
___Tyramine ___Galactans ___Fava Beans ___MSG ___Salicylates ___Polyols
___Citric acid ___Nightshades
Other, please list: _____

Please list any medications that you are taking that may interact with certain foods:

Please list your favorite foods:

Please list any foods that you dislike or cannot eat:

Any concerns you have about following a meal plan: _____
_____