

Nutritional Therapy Questionnaire

Please read and answer the following questions carefully and honestly. All information will be kept confidential and reviewed by our nutritional therapist. MJCC follows all applicable HIPAA guidelines regarding the medical information collected.

Member Name: _____ Date: _____

Do you currently follow a specific diet?

Do you have any known food allergies or intolerances?

Are you currently being treated or advised on a specific health condition by your physician?

What brings you to seek the help of a Nutritional Therapist?

Do you have any specific nutrition goals?

Are you currently taking any medications or supplements? Please list.

Have you ever taken antibiotics? Recently?



Are you pregnant?

Do you smoke?

Do you drink alcoholic beverages? If yes, how much and how often?

How many hours of sleep do you get per night? Do you feel rested when you wake up?

How would you rate your stress level on a scale of 1 – 10 with 1 being the least?

Do you exercise? How often and for how long? What type?

I understand that Nutritional Therapy services can provide guidance about health and lifestyle choices (diet, nutrition and related behaviors) in order to nourish and support health and wellness. I understand that Nutritional Therapy is not a substitute for the diagnosis, treatment, or care of disease by a medical provider and that it is recommended that individuals check with their healthcare provider before beginning any nutritional program. Any recommendations given by a nutritional therapist, including any form of supplement or vitamin, should be approved by my doctor.

I understand that if I am presently under a doctor's care that I have received his/her permission to exercise or participate in a workout program at the Mittleman Jewish Community Center.

Signature: _____ Date: _____ Staff Initials: _____

Trainer Notes: _____

