

## Cardin Center for Wellness

9159 W 133rd Street Overland Park, Kansas 66213

[www.cardinwellness.com](http://www.cardinwellness.com) 913-239-8501

### Nutritional Questionnaire

Date: \_\_\_\_\_

This is Confidential Information

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ M F  
(please circle)

Birth Date \_\_\_\_\_ Usual Weight \_\_\_\_\_ Goal  
Weight \_\_\_\_\_

E-Mail \_\_\_\_\_ Impedance \_\_\_\_\_ (We will  
measure this.)

**Are you interested in a Complimentary Nutritional  
Consultation?** \_\_\_\_\_

**Are you interested in learning more about a nutrition-counseling  
program?** \_\_\_\_\_

Have you ever participated in a **nutrition counseling program that is based on real  
food and long term lifestyle changes?** (not commercialized weight loss programs or a  
personal trainer) \_\_\_\_\_

**Most Important Reason(s)** for Considering Nutrition Counseling (start with most  
important)

\_\_\_\_\_  
\_\_\_\_\_

**What Nutritional Programs or Diets Have You Tried In The Past?** (If any)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ANSWER 1 to 10. 1 = LOW IMPORTANT 5 = MEDIUM IMPORTANT 10 = VERY  
IMPORTANT**

Is nutrition counseling for **cancer, heart disease, and disease prevention** important?

Is nutrition counseling for **weight management (reduce body fat & increase muscle)** important? \_\_\_\_\_

Is nutrition counseling for **weight gain (lean mass increase)** important?

Is nutrition counseling to **have more energy** and better workouts? \_\_\_\_\_

How many **pounds weight loss or gain** would you prefer **each week or month** (please circle)? \_\_\_\_\_ lbs

**What is a realistic Exercise Program For You to Complete Weekly?**

**LIST AT LEAST ONE PRIMARY EXERCISE (S):**

**Day**

**of Week**

1. \_\_\_\_\_ **MINUTES:** \_\_\_\_\_

2. \_\_\_\_\_ **MINUTES:** \_\_\_\_\_

3. \_\_\_\_\_ **MINUTES:** \_\_\_\_\_

Primary Physician's Name \_\_\_\_\_

Physician's Number \_\_\_\_\_

May we send your primary physician a summary of your results? Yes No (Circle one)

Person to Contact in an Emergency: \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_\_

**MEDICAL HISTORY** Do you now, or have you had in the past:

**NO**

**YES**

- 1) History of heart problems, recurring chest pain, heart murmur, or stroke
- 2) Diagnosis of Hypertension or take medicine for same
- 3) Diabetes Mellitus
- 4) Asthma, breathing or lung problems
- 5) Cancer (other than skin)
- 6) Seizures, seizure medication, neurological problems or severe dizziness
- 7) Gallbladder disease or intestinal problems
- 8) Back problem, joint or muscle disorder still affecting you
- 9) Recent surgery (last 12 months)
- 10) Hernia or any condition that may be aggravated by lifting weights
- 11) Physician's advice not to exercise

**WOMEN ONLY:**

- 12) Are you pregnant, lactating or anticipating becoming pregnant?

If your answer is YES to any question above, give *brief* explanation: \_\_\_\_\_

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- 13) History of total Cholesterol greater than 200 mg/dl  
14) Family history of coronary heart disease or other atherosclerotic disease in parents or siblings before age 55  
15) History of cigarette smoking  
16) Do you take vitamins?  
17) Are you allergic to soy?  
18) Are you allergic to lactose / dairy products?

Time	Food Eaten	Serving Size	Home or Restaurant

- 19) Are you taking any medications? If so, what?
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**Typical Daily Food Log (1 day- Minimum) Please include Meals, Snacks, Be  
Beverages & Estimate Portion Sizes**

**Disclaimer**

I understand that participating in any program of exercise, nutrition and lifestyle change has certain risks. I realize that the information I provide to determine my potential risk category and to provide a subsequent exercise and nutrition program. The information I have supplied is correct to the best of my knowledge. I also acknowledge that all participants in any program should consult their physician before embarking on such a program or taking any supplements. I take full responsibility for my participation in any of these programs for any claims for injuries or illness that may result from my participation in any of their programs.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

