Name: _____

Nutrition Worksheet

Do you have any nutrition questions or concerns?

Food Choices Carbohydrate counting Vitamin/Minerals Other supplements Other: _____

Are you following a special diet?

Vegetarian Gluten Free Dairy Free Low Carb

Other: _____

How do you count carbohydrates?

Grams Servings Both N/A

How many carbohydrates/servings do you usually eat in a day?	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Grams of Carbohydrates OR Servings						

How many times a week do you skip a meal?

Never 1 – 2 3 – 4 5 – 6 Everyday

Which meal? _____

How often do you eat low-carbohydrate/no carbohydrate foods (free-foods)?

With meals only With meals & snacks All day long

List 2 of these foods you eat most often: _____ _____

What kind of milk do you have in your house?

Skim 1% 2% Whole Flavored Soy

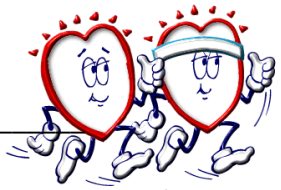
How many cups (8 oz) of milk do you drink in a day?

1 2 3 4 5+

How many times a week do you dink any of the following:

Juice - Regular Soda - Lemonade - Kool-Aid Sports/energy drinks - Sweet tea - Flavored Milk

Never 1 – 2 3 – 4 5 – 6 Everyday



What are your current physical activities/exercise?

_____

How much do you exercise?

None Less than 2.5 hrs/wk 2.5 to 5 hrs/wk More than 5 hrs/wk

Are you taking any vitamins, minerals or herbal supplements?

_____

Thank you!