NAME____

DIET AND NUTRITION INFORMATION

Please use black ink.

How often do you eat the following items? Please circle the appropriate answer:

Wheat/Gluten	Daily	Weekly	Rarely	Never
Milk/Yogurt	Daily	Weekly	Rarely	Never

How many cups of plain water do you drink per day?__________________________

How many cups of coffee or black or green tea?______________________________

How much pop/soda do you average per day?_______________________________

How often are your bowel movements?_____________________________________

What vitamins and herbs are you currently taking?_____________________________

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Typical breakfast____

Lunch____

Evening meal ____

____

Describe any head injuries____

Physician diagnosed Illnesses?____

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Have you ever had radiation therapy?_______ Chemotherapy?_______

List your three primary health concerns______________________________________

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