

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? _____

Typical breakfast _____

Lunch _____

Evening meal _____

Physician diagnosed illnesses? _____

Have you ever had radiation therapy? _____ Chemotherapy? _____

List your three primary health concerns _____
