Radiant Health Assessment

Last Name:_____First name_____
D.O.B_____/_____/_____ Current Age_____Height_____Weight_____

E-mail address_____
City_____State:_____Zip:_____
Telephone number:_____
What are your top 3 heath concerns?

1.
2.
3.

Do you take prescription medicine, supplements, herbal medications, vitamins and protein shakes? If so please list and how often.

Do you avoid categories of food (example gluten, dairy, animal products)? Explain

Do you have a food allergy or intolerance? Explain

How many times per day do you eat?

How many times per week do you eat out?

Do you cook?

How long (minutes does it take you to finish a meal?

Do you consider yourself a slow, medium or fast eater?

How often do you eat until you are stuffed or uncomfortable?

Always
Usually
Sometimes
Never

Do you do other activities while eating?

- Reading
- Watching TV
- Phone
- Other

Check all that apply:
If I am craving a certain food I don't let myself eat it.
I get mad at myself for eating a food that I think is unhealthy
I can't stop eating when I am full
I use food to soothe me
I eat when I am bored
I eat when I am lonely
I eat when I am stressed
I can't tell when I am hungry
I don't trust my body to tell me **when** to eat
I don't trust my body to tell me **what** to eat
I don't trust my body to tell me **how much** to eat
When I eat I can't tell when I am full
(Adapted from Tylca, Tracy L)

What is your motivation for changing your eating and lifestyle habits?

Thank you!! You have taken the first step towards radiant and vibrant health.

Elizabeth
www.OffTheMatNutrition.com