



WELLNESS. ADVANCED.

# nutrition CLIENT PROFILE

Date \_\_\_\_\_

Name \_\_\_\_\_

Age/ DOB \_\_\_\_\_

Address \_\_\_\_\_

Phone (Home) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

E-mail address \_\_\_\_\_

Phone (Work) \_\_\_\_\_

Check this box to receive updates on exciting promotions, events and more.

Phone (Cell) \_\_\_\_\_

How did you hear about vir tú? \_\_\_\_\_

Is it acceptable for us to contact you via e-mail?     Yes     No

Is it acceptable for us to leave messages on a voice mail/answering machine for you?     Yes     No

What brings you in for this nutritional consultation? \_\_\_\_\_

Have you been diagnosed with any major medical conditions? If so, please list below.

Please list ALL your known allergies (food, drug, etc.).

Please list all the medications, supplements, hormones, and other prescriptions you are currently taking. Include dosages if known.



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Do you drink coffee?    Y        N

Do you have any food cravings?    Y        N

If yes, how many cups per day? \_\_\_\_\_

If yes, what are they? \_\_\_\_\_

Do you drink soda?    Y        N

If yes, how many ounces per day? \_\_\_\_\_

How much water do you drink per day? \_\_\_\_\_

Circle your energy level: 1 = lowest and 10 = highest

1      2      3      4      5      6      7      8      9      10

How many hours of sleep do you get per night? \_\_\_\_\_

### TYPICAL DAILY DIET

Please include time meal/snack is usually eaten; be as specific as possible with your descriptions (include brands if applicable).

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Liquids \_\_\_\_\_