

Current Eating Habits

Please answer the questions below as honestly and frankly as possible as they will form the basis of your Nutritional Therapy sessions with Sophia.

What are your favourite foods and drinks?: _____

Do you crave any food or drink on a frequent basis? No Yes Details: _____

Is there a food item that you can't do without? No Yes Details: _____

Do you follow a special diet/ or cater for one? No Yes Details: _____

Who cooks in the household? _____

Weekly alcohol intake (units): < 5 6 - 12 13 >

Do you eat on the move/when stressed? No Yes

Do you chew your food thoroughly? No Yes

Are you ever excessively thirsty? No Yes

Do you ever have eating binges? No Yes Details: _____

How does this make you feel? _____

Have you ever suffered from an eating disorder? No Yes Details: _____

Are you sensitive/intolerant of any food or drink item? No Yes Details: _____

Are you or have you recently been on a calorie controlled diet? No Yes Details: _____

Do you feel positive about making new healthy food choices? No Yes

Food Diary

(Please give as much detail as possible and complete 3 work days and 1 weekend day)

Meal	Day 1	Day 2	Day 3	Day 4 (Sat or Sun)
Breakfast	Time: Food:	Time: Food:	Time: Food:	Time: Food:
Lunch	Time: Food:	Time: Food:	Time: Food:	Time: Food:
Dinner	Time: Food:	Time: Food:	Time: Food:	Time: Food:
Snacks	Time: Food:	Time: Food:	Time: Food:	Time: Food:
Drinks Please indicate how many you have during the day & what you have them with.	Coffee/tea: Herbal teas: Fizzy drinks: Alcohol: Other:	Coffee/tea: Herbal teas: Fizzy drinks: Alcohol: Other:	Coffee/tea: Herbal teas: Fizzy drinks: Alcohol: Other:	Coffee/tea: Herbal teas: Fizzy drinks: Alcohol: Other: