NUTRITIONAL QUESTIONNAIRE

Name and surname:

Date of birth:

Address:

Phone:

Email:

Current weight:

Height:

Waist circumference:
Arm circumference:

Hip circumference:
Chest circumference:

Thigh circumference:

Type of work/profession:

Working hours/away from home:

1. Please describe your current lifestyle (sedentary, standing, active, very active):
……
……
……

2. Please indicate the means of transportation you use during the day:
BIKE/TRAM/CAR/WALK/BUS/OTHER

3. Have you recently undergone any surgeries or suffered from chronic illnesses? If yes, what kind?
……
……

4. Do you currently have or have you ever had any of the following conditions:
- ATHEROSCLEROSIS YES/NO
- HIGH BLOOD CHOLESTEROL LEVEL? YES/NO
- HYPERTENSION YES/NO

HYPOTENSION YES/NO *
HEART DISEASE YES/NO
* KIDNEY DISEASE Y ES/NO
* HYPERTHYROIDISM YES/NO
* HYPOTHYROIDISM YES/NO
* DIGESTIVE TRACT DISEASES (ULCERS/DIARRHEA/BLOATING/CONSTIPATION) YES/NO
* REFLUX YES/NO
* CANCER YES/NO
* OSTEOPOROSIS YES/NO
* HORMONAL PROBLEMS YES/NO
* SKIN PROBLEMS YES/NO
* MIGRAINES/DEPRESSION/PAINFUL MENSTRUATION YES/NO
* ABNORMAL BLOOD SUGAR LEVELS YES/NO
* INSOMNIA YES/NO
* ASTHMA YES/NO
* AUTOIMMUNE DISEASES YES/NO
* PANCREATIC DISEASES YES/NO
* LIVER DISEASES YES/NO

If yes, when?
……
……

5. On a scale of 1-10, how would you rate your stress resistance? ……

6. Do you have any allergies to:
* POLLEN YES/NO
* FUR/DUST YES/NO
* MEDICATIONS YES/NO
* HOUSEHOLD CHEMICALS YES/NO
* COSMETICS YES/NO
* FOOD ALLERGIES YES/NO

If yes, what kind?
……

7. Have you undergone antibiotic therapy in recent years? If yes, when and how long did it last?
……

8. Do you get enough sleep? YES/NO

9. Is your sleep consistent? YES/NO

10. How many hours do you sleep? ……

11. Are there any chronic diseases in your family? If yes, what kind?
……

12. Do you take any pharmaceutical medications regularly? YES/NO
If yes, what kind and since when?
……
……

13. Do you take any dietary supplements regularly? YES/NO
If yes, what kind and since when?
……
……

14. Do you have any food intolerances? YES/NO
If yes, what kind? Have you been diagnosed?
……
……

15. When was the last time you had lab tests (blood count, urine, etc.)?
……

16. Have you ever had issues with abnormal body weight? YES/NO

17. Did you have weight problems in childhood? YES/NO

18. Have there been any issues with overweight or obesity in your family? YES/NO

19. Do you engage in physical activity? If yes, what kind and how often?
……
……

20. Have you followed any diets? If yes, please list the name or describe the diet.
……
……
……

21. What kind of dishes do you prefer in your diet?
……
……
……

22. What foods do you avoid in your diet?
……
……
……

23. How did you eat during childhood?
……
……
……

24. How many meals do you eat per day? ……

25. Do you consume ready-made sauces, mayonnaise, ketchup, ready-made mixes, etc.? If yes, what kind?
……

26. Do you consume bread? If yes, what kind and how often?

27. Is your current diet monotonous (same meal 3 times a day)? YES/NO

28. Do you consume fish or seafood? If yes, what kind and how often?

……

29. Do you consume whole grain products daily (rye bread, muesli, dark pasta, coarse grains)? YES/NO

30. Do you consume high-fat products? If yes, what kind?

……

31. What kind of fats do you use for frying?
……

32. How often do you consume vegetables? ……

33. How often do you consume fruits? ……

34. How often do you consume eggs? ……

35. What is your favorite type of meat?

……

36. How is the meat prepared?

……
……

37. Do you consume dairy products? If yes, what kind and how often?

……

38. The most frequently consumed carbohydrates by you are:
GRAINS/RICE/PASTA/DUMPLINGS/FLOUR/BREAD/SWEETS/CAKES/SUGAR/HONEY/FRUITS/
OTHER

39. What cooking techniques do you use to prepare meals?
STEWING/GRILLING/BOILING/BAKING/FRYING/STEAMING/OTHER

40. Do you consume a two-course meal for lunch? YES/NO

41. In what atmosphere do you consume your meals?

STRESS/RELAX/HURRY/OTHER

42. Do you consume sweets, chips, or other unhealthy snacks? If yes, what kind and how often?
……
……

43. Do you snack at night or between meals? YES/NO

44. Are your meals for work/school prepared by yourself? YES/NO

45. Do you eat out? If yes, what do you usually eat?

……
……

46. Do you consume fast food? If yes, what kind and how often?

……

47. How many liters and what kind of fluids do you drink daily?

……

48. How much coffee and tea do you drink daily, and what kind is it?

a) coffee
ESPRESSO/INSTANT/GROUND
- daily amount ……
* with what kind of milk? ……
* sweetened? YES/NO
* with what and how much? ……

* how much water in the glass? ……

b) tea
WHITE/GREEN/REGULAR/FRUIT/BLACK/OTHER
* daily amount ……
* sweetened? YES/NO
* with what and how much? ……
* with juice? YES/NO
* with honey? YES/NO
* with lemon? YES/NO

49. Do you drink carbonated beverages? If yes, what kind?
……

50. Do you ever skip or forget a meal? YES/NO

51. How long are the intervals between meals?

……

52. How many hours before bed do you consume your last meal?
……

53. Preferred tastes?
SALTY/SWEET/SPICY/HERBAL/SOUR/OTHER

54. What kind of spices do you use in your cooking?

55. When do you have the biggest appetite?
MORNING/EVENING/AFTER WORK/AFTER TRAINING/DURING STRESS/BEFORE BED/OTHER
……

56. Do the meals you consume make you feel full? YES/NO

57. Do you pay attention to the calorie content of meals? YES/NO

58. Do you smoke tobacco or use other substances? If yes, how often?

……

59. Do you drink alcohol? If yes, how often, how much, and what kind?
……

60. How many times a day do you have a bowel movement? ……

61. Do you have regular bowel movements? YES/NO

62. What weight would you like to achieve? ……

63. Have you experienced weight fluctuations? YES/NO

64. What are your expectations after the consultation?
WEIGHT LOSS/WEIGHT GAIN/IMPROVED HEALTH RESULTS/INCREASED ENERGY LEVELS/MAXIMIZING SPORTS PERFORMANCE/IMPROVED WELL-BEING/IMPROVED CONCENTRATION/OTHER
……
……

Space for the current meal plan (preferably 7 days)

Thank you for completing the questionnaire.
