Name:		Date:	
Address:		Email:	
Age/DOB:	Ht:	Phone:	
Referred by:		Cell:	
Recent Wt:	Desired Wt:	Highest Wt:	Wt 1 yr ago:

MEAL PLAN QUESTIONNAIRE

What are your goals / changes you would like to see?

Are there any specific health issues you are trying to improve?

List dietary limitations, food allergies, or sensitivities that you are aware of:

Are there any certain foods you really dislike? **Y / N**
- If yes, please list: _____

Are there any foods/food groups you really enjoy**? Y / N**
- If yes, please list: _____

Does a meal or snack typically hold you at least 3 hours? **Y / N**
Do you typically struggle with cravings? **Y / N**
- If yes, what type (sweet, salty, fast food etc): _____

Do you own a slow cooker? **Y / N**
Do you own a blender or food processor? **Y / N**
About how many people will be eating off this meal plan? _____

Circle your preferences for each weekly meal plan depending on time available to cook and how many leftovers you like to eat: (many prefer 1-2 for breakfast, lunch, and snack, and 3-4 for supper)

Breakfast options for the week: **1-2 recipes / 2-3 recipes / 3-4 recipes**
Lunch options for the week: **1-2 recipes / 2-3 recipes / 3-4 recipes**
Snack options for the week: **1-2 recipes / 2-3 recipes / 3-4 recipes**
Supper options for the week: **1-2 recipes / 2-3 recipes / 3-4 recipes / 5-6 recipes**

Rate average level of stress from 1 (extremely low) to 10 (extremely high): _____
{Female} Are you pregnant or breastfeeding? **Y / N**

Anything else that would be helpful for me to know?