

Eating to Fuel Health

Nutritional Information Sheet

Patient Name: _____

Do you follow a specific dietary regimen such as: (check one or more)

Low carbohydrate _____

Low fat _____

Low calorie _____

Other-explain:

Do you skip meals during the day?

What are your favorite foods?

Do you get cravings? _____ Sugar cravings? _____

Please list the names, amounts, and frequency of supplements you take on a regular basis: (you should also bring a list with you)

_____	_____
_____	_____
_____	_____
_____	_____

Additional Comments: