Personalized Meal Plan Questionnaire:

Name: _____

Surname: _____

Age: _____

Gender: _____

Height: _____cm

Weight: _____kg

Do you know your fat percentage? _____%

What time do you wake up? _____ am

What time do you go to bed? _____ pm

What time do you train (if applicable)? _____

What is your goal? _____

_____

_____

By when do you want to achieve your goal? _____

_____

_____

Exercise and Lifestyle Information

Dietary Information

1. Do you have any allergies (food or other)? _____

_____

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2. Breakdown your current diet and eating times?

	Times	Diet
Breakfast		
Lunch		
Dinner		
Snacks		

3. List of current supplements?_____

_____

_____

_____

4. List the foods that you do not like? _____

_____

_____

_____

_____

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5. Do you drink sugar with you coffee / tea? Yes ☐ No ☐

6. If yes, would you be able to use a sweeteners instead? Yes ☐ No ☐

How may cups of do you drink a day? _____

_____

7. Do you drink milk with your coffee / tea? Yes ☐ No ☐

8. Would you be able to drink black coffee / tea? Yes ☐ No ☐

9. What are your personal barriers to not eating healthy (e.g. don't have time to cook etc.)? _____

_____

_____

_____

_____

10. Have you ever started a diet but found yourself unable to stick with it?

Yes ☐ No ☐

If yes, please gives reasons why (e.g. stress at work, food temptations, negative self-talk etc.) _____

11. What diet or eating plan were you successful with in the past? _____

What was your motivation? _____

12. Do you have any negative feelings towards dieting or have you had any bad experiences before?

If yes, please explain: _____

Activity Level

1. In the past year, how often have you been engaged in physical activity?

Select an option below:

☐ Regular (3 to 4 times a week)

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☐ Semi regular (1 to 2 times a week)

☐ Sporadically (1 to 2 times a month)

☐ None

2. Are you currently doing any regular exercise? Yes ☐ No ☐

If yes, specify the type of exercise(s): _____

_____

_____

Also specify _____minutes/day _____days/week

3. Rate your perception of the exertion of your exercise program:

Light ☐ Fairy light ☐ Somewhat Hard ☐ Hard ☐

4. How long have you been exercising regularly?

_____months _____years

5. What exercise have you done in the past?_____

_____

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6. What past athletic events have you competed in? _____

7. Are you currently training for an athletic event? _____

8. Do you have any injuries? _____

Health History

1. Has your doctor ever said that your blood pressure was too high or to low?

Yes ☐ No ☐

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2. Have you ever been diagnosed with diabetes? Yes ☐ No ☐

3. Do you have any cardiovascular problems (heart disease, abnormal ECG etc.)?

Yes ☐ No ☐

If you answered yes, please describe: _____

_____

_____

4. Have you ever been diagnosed with high cholesterol? Yes ☐ No ☐

5. Are you taking any prescribed medications? Yes ☐ No ☐

If yes, what medication are you taking and for what? _____

_____

_____

6. Are you pregnant or postpartum less than 6 weeks? Yes ☐ No ☐

7. Are you breastfeeding? Yes ☐ No ☐

8. Do you have any medical conditions not previously mentioned? Yes ☐ No ☐

If you answered yes, please describe: _____

_____

_____

_____

9. Have you ever had an eating disorder? Yes ☐ No ☐

If you answered yes, please describe: _____

_____

_____

_____

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