MODERN WELLNESS

ROOT-CAUSE WELLNESS • CELLULAR LONGEVITY • BIOENERGETIC HEALTH

Personalized Nutrition & Wellness Profile

CLIENT INTAKE QUESTIONNAIRE

Please complete this form electronically so your answers are clear and easy to review.
Click into any blank field to type, and click the square boxes to select your answers.

1. ABOUT YOU

Full Name

Date

Date of Birth

Age

Height

Current Weight

Usual Weight

Goal Weight (if applicable)

☐ Female ☐ Male ☐ Prefer not to say

Occupation

Typical work schedule

2. YOUR TOP HEALTH GOALS

What are the three most important things you would like to improve?

☐ Lose body fat
☐ Gain healthy weight
☐ Improve energy
☐ Improve digestion
☐ Improve sleep
☐ Improve skin/hair/nails
☐ Reduce inflammation
☐ Mental clarity/focus
☐ Healthier eating habits
☐ Maintain weight
☐ Build/maintain muscle
☐ Improve blood sugar balance
☐ Reduce bloating
☐ Healthy aging/longevity
☐ Hormonal balance
☐ Cardiovascular health
☐ Athletic performance
☐ Other



What would make you feel that this nutrition program was successful?

3. HEALTH & MEDICAL HISTORY

- ☐ Prediabetes
- ☐ Diabetes
- ☐ Insulin resistance
- ☐ High cholesterol/triglycerides
- ☐ High blood pressure
- ☐ Thyroid condition
- ☐ Autoimmune condition
- ☐ Osteopenia/osteoporosis
- ☐ Fatty liver
- ☐ Anemia
- ☐ IBS
- ☐ GERD/reflux
- ☐ Food allergies
- ☐ Kidney condition
- ☐ Gallbladder disease/gallstones
- ☐ Heart disease
- ☐ Cancer
- ☐ Other

Gallbladder status

- ☐ I still have my gallbladder
- ☐ Gallbladder removed
- ☐ Not sure

If removed: approximate year and reason (if known)

Current medications (include names, amounts and frequency):

Current vitamins, minerals, herbs, protein powders or supplements:

Recent surgeries, injuries, major illnesses or significant health changes:



4. LABS (check all you have tested within the last year)

- [ ] Fasting glucose
- [ ] Hemoglobin A1C
- [ ] Fasting insulin
- [ ] Total cholesterol
- [ ] LDL
- [ ] HDL
- [ ] Triglycerides
- [ ] Vitamin D
- [ ] Vitamin B12
- [ ] Folate
- [ ] Iron/ferritin
- [ ] Thyroid panel
- [ ] Liver enzymes
- [ ] Kidney markers
- [ ] CBC/CMP
- [ ] Hormone testing
- [ ] Other

Date of most recent labs

Other relevant lab findings or notes:

5. DIGESTION & GUT HEALTH

How would you describe your digestion overall?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

- [ ] Bloating
- [ ] Gas
- [ ] Burping
- [ ] Heartburn/reflux
- [ ] Constipation
- [ ] Diarrhea
- [ ] Alternating constipation/diarrhea
- [ ] Abdominal discomfort
- [ ] Overly full after meals
- [ ] Undigested food in stool
- [ ] Food sensitivities/intolerances
- [ ] None

How often do you typically have a bowel movement?

Foods that consistently cause digestive problems:

Previous digestive diagnoses/treatment (IBS, SIBO, H. pylori, Candida, parasites, etc.):

6. ENERGY, STRESS & SLEEP

How would you rate your daily energy?

- [ ] Excellent
- [ ] Good
- [ ] Fair
- [ ] Poor

When is your energy lowest?

- [ ] Morning
- [ ] Late morning
- [ ] Afternoon
- [ ] Evening
- [ ] Fluctuates

- [ ] Afternoon crashes
- [ ] Strong sugar cravings
- [ ] Shaky/irritable when hungry
- [ ] Brain fog
- [ ] Difficulty concentrating
- [ ] Frequent fatigue

Average stress level (1-10)

Average hours of sleep

Primary sources of stress:

Usual bedtime

Usual wake time

- [ ] Fall asleep easily
- [ ] Difficulty falling asleep
- [ ] Wake during night
- [ ] Wake too early
- [ ] Wake refreshed
- [ ] Wake tired

7. ACTIVITY & EXERCISE

- [ ] Mostly sedentary
- [ ] Lightly active
- [ ] Moderately active
- [ ] Very active
- [ ] Extremely active/athletic

- [ ] Walking
- [ ] Strength training
- [ ] Cardio
- [ ] Yoga/Pilates
- [ ] Cycling
- [ ] Swimming
- [ ] Sports
- [ ] Other

Days per week

Minutes per session

Average daily steps

Trying to increase muscle or strength?

- [ ] Yes
- [ ] No



8. YOUR CURRENT EATING STYLE

- [ ] No specific diet
- [ ] Low carbohydrate
- [ ] Paleo
- [ ] Vegan
- [ ] Gluten-free
- [ ] Intermittent fasting
- [ ] Mediterranean-style
- [ ] Keto
- [ ] Vegetarian
- [ ] Pescatarian
- [ ] Dairy-free
- [ ] Other

Typical eating window (if fasting)

Meals/day

Snacks/day

- [ ] Usually eat breakfast
- [ ] Frequently eat after dinner
- [ ] Frequently eat restaurant/takeout meals

If restaurant/takeout meals are frequent, approximately how often?

9. FOOD PREFERENCES & RESTRICTIONS

Known food allergies:

Food sensitivities/intolerances:

Foods you strongly dislike:

Foods you love and would like included:

Foods you are willing to eat:

- [ ] Eggs
- [ ] Fish
- [ ] Seafood
- [ ] Poultry
- [ ] Red meat
- [ ] Dairy
- [ ] Legumes
- [ ] Nuts/seeds
- [ ] Whole grains

Religious, cultural, ethical or personal dietary restrictions:



10. HYDRATION & BEVERAGES

Water/day (oz or glasses)

Coffee/caffeine/day

Alcohol/week

- [ ] Coffee
- [ ] Tea
- [ ] Soda
- [ ] Diet beverages
- [ ] Energy drinks
- [ ] Juice
- [ ] Alcohol
- [ ] Electrolyte beverages
- [ ] Protein drinks/smoothies

11. CRAVINGS & EATING PATTERNS

How often do you experience cravings?

- [ ] Rarely
- [ ] Occasionally
- [ ] Daily
- [ ] Several times daily

- [ ] Sugar/sweets
- [ ] Chocolate
- [ ] Bread/pasta
- [ ] Salty foods
- [ ] Crunchy foods
- [ ] Fatty foods
- [ ] Other

When are cravings strongest?

- [ ] Morning
- [ ] Afternoon
- [ ] Evening
- [ ] Late night
- [ ] During stress

Do you ever eat because of:

- [ ] Stress
- [ ] Boredom
- [ ] Anxiety
- [ ] Habit
- [ ] Social situations
- [ ] Fatigue
- [ ] Reward/comfort

12. WEIGHT & METABOLIC HISTORY

Significant weight changes during the past five years? Please explain:

Where do you tend to gain weight?

- [ ] Abdomen
- [ ] Hips/thighs
- [ ] Upper body
- [ ] Throughout the body

Previous diets or weight-loss programs:

What worked?

What did not work or was not sustainable?

13. WOMEN'S HEALTH - IF APPLICABLE

- [ ] Regular menstrual cycles
- [ ] Perimenopause
- [ ] Menopause
- [ ] Post-menopause
- [ ] Hysterectomy
- [ ] Other

Currently using hormone replacement therapy?

- [ ] No
- [ ] Yes

If yes, please list:

- [ ] Hot flashes
- [ ] Night sweats
- [ ] Sleep disruption
- [ ] Mood changes
- [ ] Weight redistribution
- [ ] Loss of muscle
- [ ] Other

14. 3-DAY FOOD DIARY

Record everything you eat and drink for three typical days - ideally two weekdays and one weekend day.
Include portions, brands, cooking methods, oils, dressings, sauces, sweeteners and supplements.

3-DAY FOOD DIARY | DAY 1

Expanded writing space for Section 14. Enter foods, drinks, portion sizes and details.

Day / date:

Breakfast

Morning snack

Lunch

Afternoon snack

Dinner

Evening food / snacks

Beverages, oils, sauces & extras

3-DAY FOOD DIARY | DAY 2

Expanded writing space for Section 14. Enter foods, drinks, portion sizes and details.

Day / date:

Breakfast

Morning snack

Lunch

Afternoon snack

Dinner

Evening food / snacks

Beverages, oils, sauces & extras

3-DAY FOOD DIARY | DAY 3

Expanded writing space for Section 14. Enter foods, drinks, portion sizes and details.

Day / date:

Breakfast

Morning snack

Lunch

Afternoon snack

Dinner

Evening food / snacks

Beverages, oils, sauces & extras



15. PERSONALIZED PLAN PREFERENCES

- ☐ Calorie/macronutrient targets
- ☐ Detailed nutrient analysis
- ☐ Foods to reduce
- ☐ Gut-supportive nutrition
- ☐ Healthy-aging/longevity nutrition
- ☐ Meal ideas
- ☐ Grocery list
- ☐ Eating-out strategies
- ☐ Protein goal
- ☐ Foods to increase
- ☐ Blood-sugar-supportive plan
- ☐ Anti-inflammatory nutrition
- ☐ Weight-management strategy
- ☐ Recipes
- ☐ Supplement considerations
- ☐ Other

How much structure would you prefer?

- ☐ Very structured - tell me exactly what to eat
- ☐ Moderately structured - meals and options
- ☐ Flexible - guidelines and choices

16. OPTIONAL BIOENERGETIC INFORMATION

Have you completed Qest4 Bioenergetic Testing with Modern Wellness?

- ☐ Yes
- ☐ No

Relevant Qest4 findings or notes (practitioner may complete):

17. ANYTHING ELSE WE SHOULD KNOW?

Anything about your health, lifestyle, relationship with food, schedule, budget, cooking ability or goals that would help us create a plan you can realistically follow?

18. CLIENT ACKNOWLEDGMENT

I understand that this questionnaire supports nutrition education and wellness planning and does not replace medical diagnosis, treatment, or care from a licensed medical professional. I will discuss significant medical concerns with my healthcare provider and have provided accurate information to the best of my knowledge.

Client name

Date

Signature (type name as electronic acknowledgment)

Please return your completed form to: ModernWellnessAZ@gmail.com