Diet Evaluation Questionnaire

Name:

Phone Number:

Email:

Answer:	Never/Almost Never	Occasionally	Frequently
Do you skip breakfast?			
Do you eat breakfast cereal, bagel or donuts?			
Do you eat fruit flavored yogurt?			
Do you eat 3 or more servings of fruit in a day?			
Do you skip lunch?			
Do you eat at your desk while continuing to work?			
Do you eat cheese?			
Do you eat bread?			
Do you eat dinner after 7:00 PM?			
Do you pick up dinner from a fast food restaurant?			
Do you eat in the car?			
Do you eat in front of the TV?			
Do you eat vegetables with your meals? Do you use bottled salad dressing?			
Do you have dessert?			

Diet Evaluation Questionnaire

	Never/Almost Never	Occasionally	Frequently
Do you eat right up until the time you go to bed?			
Do you get less than 7-9 hours of sleep at night?			
Do you have heartburn/acid reflux?			
Do you feel bloated after you eat?			
Do you have chronic constipation?			
Do you have body aches and pains?			
Do you have dry itchy skin?			
Do you have trouble focusing and remembering things?			
Do you frequently clear your throat?			
Do you have excess weight you just can't lose?			

Never/Almost Never = 1 point
Occasionally = 2 points
Frequently = 3 points

Please send completed forms to Kathy@VibranceForLife.com for consultation.