
DIET QUESTIONNAIRE

Please answer the following questions and return to me.

Fax: 315-295-2208 (Or deliver in person.)

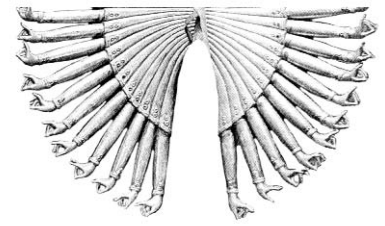
Email: waters@lifesourceacupuncture.com

Name: _____

Date: _____

Email Address: _____

Phone Numbers: _____



LIFE SOURCE
ACUPUNCTURE

Jennifer Waters, L.Ac.

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Syracuse, NY 13210

315-423-8614

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1. What is the first thing you consume in the morning?
 2. What time is that typically?
 3. How much water do you drink per day?
 4. What kind of water are you drinking?
 5. What is your ideal weight?
 6. What is your current weight?
 7. What kind of caffeine (ie. coffee, tea, soda, chocolate, etc.) do you consume and how much?

 8. What is a typical breakfast menu?
 9. What is a typical lunch menu?
 10. What is a typical dinner menu?
 11. What is a typical snack menu?
 12. Do you know your blood type? Yes No
If so, what is it?
 13. How much time do you spend preparing foods per day? _____ Per week? _____
 14. Are you willing to spend more time? Yes No
 15. How do you eat meals? Standing Sitting Alone Other _____
 16. Do you take supplements? Yes No
Which ones?
How many?
How long have you been taking them?
 17. Have you ever done any cleansing or detoxifying? Yes No
 18. Do you have a bath tub? Yes No
Are you willing to take baths? Yes No
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19. Are you interested in, or willing to make and drink herbal infusions? Yes No
20. How often do you have a bowel movement?
 Several times per day Daily Every other day 2-3 per week Other _____
21. What is the consistency? Soft Loose Dry Hard Other _____
22. What is your largest meal of the day?
What time is that?
23. What time do you eat dinner?
24. What would you say that you eat for?
 Flavor Pleasure The feeling created Nutrition Other _____
25. Do you eat anything organic? Yes No
26. Are you willing to spend more money on organic food? Yes No
27. Where do you typically shop?
28. What restaurants do you like?
29. What is the one food that you think you could never give up?
30. What are the three worst foods you eat each week?
31. What are the three healthiest foods you eat each week?
32. What were your childhood eating habits?
33. Do you feel tired or bloated after eating? Yes No
34. Have you been tested for food allergies? Yes No
If so, what were the results?
35. Have you had your thyroid tested? Yes No
If so, what were the results?
36. What have other health professionals told you about your health?
37. What is your opinion of your health and diet?
38. What would you like to change the most?