APOCALYPSE
FITNESS
PERSONAL TRAINING

NUTRITION CONSULTATION FORM

CLIENT INFORMATION

Name: Date:

Date of Birth: Height: (Feet) (Inches)

Current Body Weight (kg/lbs): Desired Body Weight (kg/llbs):

Email: Phone:

Address: Postcode:

Gender: Choose an item. Male If Other, please specify:

Preferred Pronouns: Occupation: Working Hours:

GP Name and Address:

Emergency Contact Name: Relationship to you:

Emergency Contact Phone:

NUTRITION & FITNESS GOALS

What are your Nutrition & Fitness Goals?

1.
2.
3.
4.
5.

What are your reasons behind wanting to achieve these goals?

What has prompted you to seek nutritional advice at this time?

How ready are you to make lifestyle changes? (Choose #) **(Not Ready 1 2 3 4 5 Very Ready)**

What have you tried in the past to achieve your nutrition & fitness goals?
This includes any diet or exercise program, supplement use, books, etc?

MEDICAL HISTORY & MEDICATIONS

Please list any existing health conditions or chronic diseases (e.g., diabetes, heart disease, high blood pressure, etc)

Please detail any past surgeries.

List all current medications and dosages.

List any supplements or vitamins currently taken (include brand and dosage).

Do you have family history of the following? (check all that apply)

High Blood Pressure ☐ High Blood Cholesterol☐ Diabetes ☐ Thyroid Disease☐ Obesity ☐
Heart Disease☐ Cancer ☐ Other☐

If Other please specify

Do you have any allergies or intolerances to medications or foods? If so, please specify below.

Do you currently use any of the following substances? (Select all that apply)

☐Cigarettes
☐Vapes/e-cigarettes (nicotine)
☐Chewing Tobacco or Snuff
☐Cannabis (Smoking or Vaping)
☐Edible Cannabis Products
☐I don't use any of these
☐I would prefer not to say

If any of the above have been selected: "How often do you use these substances?"

☐Daily
☐A few times per week
☐Occasionally
☐Rarely
☐I'm trying to quit

How often do you Drink Alcohol?

☐Daily
☐A few times per week
☐Occasionally
☐Rarely
☐I'm trying to quit

GENERAL MOOD AND STRESS

How would you describe your general mood most days?

☐ Positive & stable ☐ Anxious or low at times ☐ Frequently low, stressed, or overwhelmed

How would you rate your stress level? (choose #) (Low 1 2 3 4 5 High)

How do you cope with daily stressors?

Do you feel your current stress level affects your eating habits?

☐ Not at all ☐ Occasionally ☐ Often ☐ All the time

What are your main sources of stress? [e.g. work, finances, family, self-image, etc)

EMOTIONAL EATING & TRIGGERS

Do you eat more or less when you feel stressed, sad, anxious, or bored?

☐ No change ☐ I eat more ☐ I eat less ☐ It depends

Do you turn to food for comfort, reward, or distraction?

☐ Rarely ☐ Sometimes ☐ Often

Are there specific emotions that trigger overeating or under-eating?

RELATIONSHIP WITH FOOD

How would you describe your relationship with food?

☐ Balanced ☐ I often feel guilty after eating ☐ I frequently diet or restrict ☐ I binge eat or lose control at times

Do you feel in control of your eating habits?

☐ Yes ☐ Sometimes ☐ No

Have you ever been diagnosed with or experienced disordered eating (e.g., binge eating, anorexia, bulimia)?

☐ Yes ☐ No ☐ Prefer not to say

SLEEP & ENERGY

How would you rate your average sleep (quality and duration)?

☐ Excellent ☐ Fair ☐ Poor

Average number of hours sleep each night:

Is your sleep restful?

☐ Yes ☐ No

Do you often feel tired, low in energy, or burnt out?

☐ Rarely ☐ Sometimes ☐ Most of the time

SUPPORT SYSTEM & MOTIVATION

Do you feel supported by friends/family in your health journey?

☐ Yes ☐ No ☐ Not sure

What motivates you to make changes to your nutrition or health?

Are there emotional or mental barriers that could affect your progress?

NUTRITION

What 1 or 2 things would you like to change about your diet?

What eating habits are you most proud of?

What eating habits need the most improvement?

What foods do you dislike?

What foods do you crave?

What is your usual eating pattern (check all that apply):

☐varies day to day ☐varies week vs. weekend ☐grazer ☐no pattern/random
☐ skip meals ☐nighttime eating ☐3 meals/day ☐3 meals + snacks

Who performs the cooking/shopping? **What grocery store?**

How would you rate your cooking skills? (choose #) **(Inexperienced 1 2 3 4 5 Skilled)**

Do you read food labels? If yes, what do you look for?

What do you drink with meals and in-between meals?

If you snack, what do you usually snack on?

How often do you travel?

Out of 7 days, how often do you dine out for: Breakfast? Lunch? Dinner?

What types of restaurants do you typically frequent?

How often do you eat in front of the TV or computer?

What triggers you to eat? (check all that apply)
☐ time of day ☐ hunger ☐ seeing/smelling food ☐ emotions ☐ boredom ☐ other If Other, please specify:

Do any religious practices or food philosophies affect your diet (ex: Kosher, Vegetarianism)? (Please Describe)

Do you have any food allergies, intolerances or other restrictions that affect your diet? E.g. Nut Allergy, Lactose intolerance, Gluten intolerance etc (Please Describe)

Do you eat more rapidly than others? ☐ Yes or ☐ No

Do you eat until feeling uncomfortably full? ☐ Yes or ☐ No

Do you eat large amounts of food when you are not feeling physically hungry? ☐ Yes or ☐ No

Do you eat alone because of being embarrassed by how much you eat? ☐ Yes or ☐ No

Do you feel disgusted, depressed, or guilty after overeating? ☐ Yes or ☐ No

Do you feel that you cannot control the amounts you are eating? ☐ Yes or ☐ No

Do you have a history of the following? (check all that apply) ☐ compulsive over eating
☐ binge eating disorder ☐ anorexia ☐ bulimia ☐ prefer not to say ☐ other

What diets have you tried to lose weight?

How confident are you about the amount of current nutrition knowledge you have? (Low 1 2 3 4 5 High)

How confident are you about your ability to apply the nutrition knowledge you have? (Low 1 2 3 4 5 High)

CURRENT DIET

Describe your typical daily diet, including breakfast, lunch, dinner, snacks:

Breakfast

Lunch	
Dinner	
Snacks	

Beverage Consumption:

List types and amounts of beverages consumed in a typical day (e.g., water, coffee, tea, alcohol)

Portion Size:

1. How would you describe your typical portion sizes?

☐ **Smaller than average**
☐ **Average**
☐ **Larger than average**
☐ **I'm not sure**

2. Do you usually eat until you are:

☐ **Just satisfied**
☐ **Full**
☐ **Very full or stuffed**
☐ **It varies**

3. Do you often go back for second helpings?

☐ **Never**
☐ **Occasionally**
☐ **Often**
☐ **Always**

4. Are you aware of how much food you eat in a sitting (e.g. do you measure, weigh, or eyeball portions)?

☐ **Yes, I track carefully**
☐ **I estimate roughly**

☐ Not really / I eat until full
☐ I tend to graze throughout the day

Cooking Methods:

1. What are your most common cooking methods? (Tick all that apply)

☐ Frying in oil or butter
☐ Oven-baking or roasting
☐ Grilling
☐ Boiling or steaming
☐ Air frying
☐ Microwaving
☐ Takeaways / ready meals / convenience foods

2. Do you regularly use added fats when cooking (e.g. butter, oil, cream)?

☐ Yes – often
☐ Sometimes
☐ Rarely
☐ Never

3. What types of oils or fats do you use most when cooking?

☐ Olive oil
☐ Vegetable oil
☐ Coconut oil
☐ Butter/lard
☐ Low-calorie spray
☐ I'm not sure

4. How often do you eat fried, deep-fried, or heavily sauced foods?

☐ Daily
☐ A few times a week
☐ Occasionally
☐ Rarely or never

PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day?

What, if any, regular exercise do you participate in? How often? (describe)

What physical activity would you like to do that you are currently not doing?

If you answer yes to any of the following questions, check with your doctor before starting an exercise program:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor? ? ☐ Yes or ☐ No

Do you feel pain in your chest or shortness of breath when you do physical activity?
☐ Yes or ☐ No

In the past month, have you had chest pain when you were not doing physical activity?
☐ Yes or ☐ No

Do you lose your balance because of dizziness or do you ever lose consciousness? ☐ Yes or ☐ No

Do you have a bone/joint problem that may worsen by a change in your physical activity?
☐ Yes or ☐ No

Is your doctor currently prescribing drugs for your blood pressure or heart condition?
☐ Yes or ☐ No

Do you know any other reason why you should not do physical activity? ☐ Yes or ☐ No

PREVIOUS NUTRITION SUPPORT & GOALS

1. Have you worked with a nutritionist, dietitian, or followed a specific nutrition plan before?
(Please provide details: when, for how long, and what the focus was.)

2. What were the outcomes or changes you experienced from that approach?
(Include any physical, mental, or lifestyle results you noticed.)

3. What motivated you to seek a new approach or support now?

4. Is there anything you'd like to do differently this time, or anything you want to avoid based on past experiences?

If you have any questions, concerns or anything you'd like to discuss before starting your nutrition plan or working together, please feel free to share them below. This can include dietary preferences, health worries, uncertainties about the process, or anything else you feel is important. (*There are no wrong questions – feel free to be open and honest here).*

Acknowledgment of Purpose

I confirm that I have read and understand the purpose of this form, which is to provide relevant background information to support the development of a personalised nutrition plan. I understand that the information I provide will be used to help guide my nutrition and wellness support in a safe, tailored, and effective manner.

Client Signature:

Date:

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