real healing
NUTRITION

GROCERY STORE TOUR FORM

First Name ______________________ Last Name ______________________

Email ______________________ Today's Date ______________________

Age __________ Ethnic background/Birthplace ______________________

Current weight ______________________ Ideal Weight ______________________

Please fill out the following chart for each member in your household

Name	Age	Hours of sleep a night	Stress level 1-10	Energy level 1-10	Blood type

How is the digestion of the members in your household (any constipation, diarrhea, gas)?

Member #1 ____

Member #2 ____

Member #3 ____

Member #4 ____

Please list current supplements, vitamins and medications for each member in your household

Member #1 ____

Member #2 ____

Member #3 ____

Member #4 ____

Use a microwave? If so, how often? ______________________________

What percentage of your food is home cooked? ______________________

PLEASE EMAIL YOUR COMPLETED FORM TO lindsay@realhealingnutrition.com

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Please list your chief health concerns/health goals for your household

Health Goal/Concern #1: ____________________

Health Goal/Concern #2: ____________________

Health Goal/Concern #3: ____________________

Health Goal/Concern #4: ____________________

Please list what you typically eat in your household for

Breakfast ____________________

Mid Morning Snack ____________________

Lunch ____________________

Afternoon Snack ____________________

Dinner ____________________

Desserts ____________________

Liquids ____________________

Please fill out the following chart and list examples of the foods that are being craved for each member in your household (example for sweets; chocolate, cookies, pie, etc.). If you or your family member don't like a certain flavor, it's ok to leave it blank.

Name	Spicy	Bitter	Salty	Sweet	Sour

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Please indicate if in your household you eat the following by placing an "N" for never, "O" for often, or "S" for sometimes in the blank next to each item:

Item		Item	
Beef	________	Chicken	________
Pork	________	Eggs	________
Fish	________	Cow's Milk	________
Goat milk products	________	Cheese	________
Butter	________	Sushi or raw meat	________
Pastries/cookies	________	Margarine/Shortening	________
Fried Foods	________	Yogurt	________
Brown Rice	________	White Rice	________
Amaranth	________	Millet	________
Quinoa	________	Wheat Bread	________
White pasta	________	Wheat Pasta	________
Buckwheat	________	Oats	________
Beans	________	Tofu	________
Tempeh	________	Miso	________
Nuts and or seeds	________	Nut Butter/Tahini	________
Candy	________	Ice Cream	________
Soda	________	Alcohol	________
Sparkling Water	________	Coffee	________

Disclaimer of Health Care Related Services: Any advice given should never be used as a substitute for the medical advice from your own doctor. Always consult your own General Practitioner (GP) if you are concerned about your health or have questions. Your Nutritionist is not acting in the capacity of a doctor, psychologist or other licensed or registered professional. Additionally your Counselor/Nutritionist will not diagnose any disease, condition or other physical or mental ailment of the human body. If the terms of this Agreement are acceptable, please sign the acceptance below. Thank you and we appreciate the opportunity to work with you.

____ Signature

________________ Date

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