CENTER FOR BALANCED HEALTH

Nutritional Information Sheet

Patient Name:_____

Do you follow a specific dietary regimen such as: (check one or more)

Low carbohydrate_____
Low fat _____
Low calorie _____
Other-explain:

_____

_____

Do you skip meals during the day?

_____

_____

What are your favorite foods?

_____

_____

Do you get cravings?_____ Sugar cravings?_____

Please list the names, amounts, and frequency of supplements you take on a regular basis: (you should also bring a list with you)

_____ _____
_____ _____
_____ _____
_____ _____

Additional Comments:

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