Better **Gut** Better **Health**, L.L.C.

Meal Planning Questionnaire

Name: ____

Age: _____________ **Gender:** ☐ Male ☐ Female

Height: _____________ **Weight:** _____________

Email: ____

What type of meal planning do you need help with?

- ☐ Elimination diet
- ☐ Low-FODMAP diet
- ☐ Allergen-free diet
- ☐ Weight loss
- ☐ General healthy eating
- ☐ Anti-Candida diet
- ☐ Vegan or Vegetarian diet
- ☐ Athletic diet
- ☐ Diabetic diet
- ☐ Other (please specify):

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Please list any:

Food allergies	**Food intolerances**	**Food dislikes**

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Please list what you typically eat for:

	Foods eaten (e.g., eggs with toast, oatmeal, etc.)	**Where eaten?** (e.g., home, car, work, etc.)
Breakfast		
AM snack		
Lunch		
Afternoon snack		
Dinner		
PM snack		

Who is responsible for grocery shopping? ☐ Self ☐ Other

Who is responsible for cooking? ☐ Self ☐ Other

How many meals do you eat out per week? ________________

Are you interested in learning about meal prepping? (Prepping meals or ingredients ahead of time) ☐ Yes ☐ No

Are you interested in utilizing meal delivery services? (Delivery of recipes/ingredients or fully prepared meals) ☐ Yes ☐ No

Please share any additional information that may be relevant:

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