# FOOD 101

*...an introduction to medicine that tastes good*

## Registration + Intake Form

### Instructions

Please give yourself enough time to fill out this comprehensive form. You will need to email it once payment is made to food101program@gmail.com. Do not email your Food + Reaction Recall Diary (last page of the Registration + Intake Form). Instead, bring it to the first class and be prepared to hand it in at that time. If you need more room to answer completely, feel free to write on the back or add an additional page.

*PREREQUISITE:* Must be willing and eager to learn to cook.

*PLEASE NOTE:* This course is not appropriate for those with Type-1 Diabetes Meletis

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## Registration + Intake Form

Date: _____

Name:_____

Address:_____

Date of Birth:_____ Age: _____ Weight: _____ Height: _____

Male/Female: _____ Email Address: _____

Occupation: _____ Hrs/week:_____

Health Care Providers + Contact Info:

_____

_____

How would you rate your general health: Poor Fair Good Excellent

List the health goals that you would like to work on:

_____

_____

Do you - Smoke: _____ for how long: _____ Drink alcohol: _____ How Much: _____

Exercise: Y / N Kind of exercise + frequency: _____

On a scale of 1 to 10, rate your stress level and say why: _____

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How is your concentration focus? _____Hours of sleep/night: _____

## FOOD

How would you rate your diet: Poor Fair Good Excellent

Would you say you eat a well-balanced, healthy diet? _____ Why (not)?: _____

_____

If you think you can eat better, what is stopping you? _____

What foods do you crave? _____

When do you crave these foods? _____

Any Food Allergies/Sensitivities that you know of?: _____

What happens when you eat these foods? _____

Do you eat regularly? _____ Do you eat when you're hungry? _____ or stressed?: _____

List 10 of your favourite foods: _____

_____

_____

Do you like to cook? _____ What are two of your favourite dishes to cook? _____

_____

If you do not cook, why? _____

Are you wiling to learn to cook? _____

Do you eat in front of the TV/Screen?: _____ How often?: _____

Do your family members eat the same dinner each evening? _____ different dinners? _____

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How many times a week do you cook? _____ How many times a week do you eat out? _____

When you eat out, what is your favourite restaurant? _____

Why: _____

Do you tend to order the same foods at the same restaurants? _____

Have you ever been on a diet before?

| Diet | Reason | Result |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Practically speaking, what kind of support do you think you need to achieve your health goals?

_____

_____

I understand the information in the **FOOD 101**, *an introduction to medicine that tastes good* program is of a nutritional nature and not intended as a medical diagnosis or medical advice. It is strongly recommended that you inform your doctor that you intend to participate in a plant-based, Mediterranean-style nutritional program. This program is not appropriate for anyone with Type-1 Diabetes Mellitus (T1DM). By signing this form you are declaring you do not have T1DM.

_____ _____

Signature Date

## Food + Reaction Recall Diary

Please record the food and drink you consume over a 4 day period and indicate how you feel (gas, bloating, headache, tired, stiff joints, etc)

| Meals | Day 1 | Day 2 | Day 3 | Day 4 |
|---|---|---|---|---|
| Breakfast:<br><br>Time: | | | | |
| Snack:<br>Time: | | | | |
| Lunch:<br><br>Time: | | | | |
| Snack:<br>Time: | | | | |
| Dinner:<br><br>Time: | | | | |
| Snack:<br>Time: | | | | |
| How I Felt | | | | |