Let Your Kitchen be Your Workshop Consultation Form

General Information

Name: ____

Address: ______________________________ City: ______________ Zip: _______

Home Phone: ________________________ Cell Phone: ________________________

One on One Health & Wellness Instruction

Email: ______________________________________
Is this service for individual or family nutrition: Individual ___ Family ___
If family please list the name and ages of your children: ____________________________

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Please find below a list of specific wellness areas you may enjoy expanding your knowledge on:

Pantry makeover for hidden ingredients: Y or N

Shopping tour to learn diet restrictive foods: Y or N

Learning to substitute ingredients for healthy or diet restrictive options: Y or N

Learning to use a variety of vegetables and cooking methods for them: Y or N

Getting more vegetables into our daily routine: Y or N

Cooking with whole grains and legumes: Y or N

Vegetarian Cooking: Y or N

Healthy breakfast, lunch or dinner ideas: Breakfast ___ Lunch ___ Dinner ___

Healthy snack or sweet treats: Y or N

Increasing healthy fats in our diet: Y or N

Special Concerns and Food Allergies

Special diet, food allergies or health concerns for yourself or a family member: Y or N
If yes please explain:____

____

Learn how to boost your immune system with foods: Y or N

Diet & Culinary Skill Level

Have concerns with digestion distress or problems with gas and bloating after meals: Y or N
Below are questions related to the current diet you or your family consumes:

Are you or a family member vegetarian or vegan? Y or N ______________________________

Do you consume a variety of fruits and vegetables each day: Y or N

Do you cook: Y or N

Do you enjoy cooking: Y or N

What is your current level with creativity in cooking: None ___ Somewhat ___ Very ___

Are you comfortable cooking a variety of proteins: Y or N

Do you feel limited on the variety of foods you are currently cooking with: Y or N

How many meals per week do you cook? 1-3 _____ 2-4 _____ 5-7 _____

Are you creative with trying new recipes? Y or N

Do you have a well stocked kitchen with pots, pans and gadgets? Y or N

Do you use a microplane Y or N

What types of ethnic cuisine do you enjoy cooking for your family? ______________________

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Are there any ethnic cuisines that you would enjoy learning how to cook? ________________

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Diet & Culinary Skill Level - continued

Please circle a number in the following questions (1 being no experience & 5 being proficient):

How comfortable are you in the kitchen? 1 2 3 4 5

Creating juicy chicken either whole breast, stuffed breast, or shredded 1 2 3 4 5

Confidence on when your food is fully cooked 1 2 3 4 5

Cooking fish or shellfish, roasting whole steaks, creating patties or pan sautéing 1 2 3 4 5

Stir frying meats to produce tender chicken, beef and pork 1 2 3 4 5

Breading proteins 1 2 3 4 5

Enjoy creating sauces, stir fry sauces and savory dips for entrees 1 2 3 4 5

Vegetable roasting, steaming and sautéing 1 2 3 4 5

Cook with a large variety of vegetables 1 2 3 4 5

Working with a variety of greens both raw and/or cooked 1 2 3 4 5

Working with vegetables to create mock pasta and rice 1 2 3 4 5

Cook with a large variety of whole grains and legumes 1 2 3 4 5

Cooking without a recipe and having the freedom of creativity 1 2 3 4 5

Creativity with vinaigrettes for salads and grain salads 1 2 3 4 5

Baking with alternative flours 1 2 3 4 5

Baking with alternative sugars 1 2 3 4 5

Making home made nut milks 1 2 3 4 5

Making healthy go to snacks and bars 1 2 3 4 5

The statements below describe your relationship with food:

Food is nutrition and fuels the cells in my body to keep me healthy: Y or N

Food is a comfort and helps me when I am emotionally stressed: Y or N

Food is an afterthought in my busy schedule: Y or N

I find it difficult to make healthy choices: Y or N

Client Statement

I understand and acknowledge, voluntarily, that the services hereby provided are at all times restricted to consultation on the subject of health matters and intended for general well-being and are not meant for the purposes of medical diagnosis, treatment of prescribing of medicine for any disease, or any licensed or controlled act which may constitute the practice of medicine.

Name (printed): ____

Signature: ____

Date: ______/_______/_______

I look forward to our consultation and the opportunity to work with you toward your health goals!

Sherri Beauchamp,
Holistic Health Coach, AADP

Below this space please feel free to write any additional information so that I'm sure to dedicate our time together on your areas of interest and concern. ~ Thank you, Sherri

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