Personalized Health Blueprint Assessment Form

About you and your health goals

Your answers help us build your Personalized Health Blueprint around your health, food preferences, and routine. Type into the boxes or print and write by hand. If a question doesn't apply, write "N/A."

Participant information

Full name

Date completed

Date of birth

Height (optional)

Current weight (optional)

Email

Phone

Symptoms, goals, and diagnoses

What would you most like to improve over the next 30 days?

What symptoms or health concerns do you want to address? List your top three.

For each, tell us when it started, how often it happens, and what makes it better or worse.

What conditions has a healthcare professional diagnosed?

List each diagnosis and when it was made, if known. Write "none" or "unsure" as applicable.

Any other health information that may affect your nutrition? (Optional)

Examples include recent surgery, pregnancy or breastfeeding, or an upcoming treatment.

Personalized Health Blueprint Assessment Form

Medicines, allergies, and food restrictions

List current medicines and products, including anything you take only as needed.
Write “none” or “unsure” where applicable. You can attach a current medication or supplement list.

Medicines and supplements

Prescription and over-the-counter medicines, vitamins, herbs, teas, and other supplements

Name and strength	Dose taken	When / how often	Reason, if known

Allergies and other food reactions

Do you have any food allergies?
List each food or ingredient, the reaction, and whether you must also avoid trace contact.

Do you have any allergies to medicines, herbs, or supplements?
List each product and the reaction.

Which other foods cause symptoms or are hard to tolerate?
List the food, what happens, and how soon you notice it, if known.

Has your healthcare team asked you to follow any diet or fluid restrictions?
Include what to limit or avoid and any amounts you were given.

Personalized Health Blueprint Assessment Form

What you eat and drink now

Think of a typical day. Include approximate times and portions if you know them.
If you usually skip a meal, write “skip.”

A typical day

Meal or snack	Usual time	Usual foods, drinks, and portions
Breakfast		
Lunch		
Dinner		
Snacks		
Late-night eating		

What do you drink throughout the day, and about how much?
Include water, coffee, tea, sweetened drinks, and alcohol, as applicable.

How does your eating change on weekends, work shifts, or travel days?
Include how often you eat out or order in and where you usually go.

What do you notice about digestion, appetite, energy, or cravings around meals?
If relevant, include bowel habits or patterns such as reflux after dinner or an afternoon energy dip.

What about your sleep, activity, stress, or schedule affects how you eat? (Optional)

Personalized Health Blueprint Assessment Form

Food preferences and what works for you

Tell us what you'd enjoy eating and what's realistic for your household, schedule, and budget.

Foods to include or leave out

Which foods and meals would you like included?

Think of favorite breakfasts, lunches, dinners, snacks, proteins, fruits, vegetables, and grains.

Which foods should we leave out because you dislike them?

Include textures, flavors, or smells you avoid.

What eating style or food traditions would you like us to honor?

Include dietary preferences, cultural or religious practices, and foods your household shares.

Shopping, cooking, and eating away from home

Who shops and cooks, and how much time can you spend preparing meals?

Tell us about your grocery budget, food access, kitchen equipment, or cooking skills if relevant.

What would make your meal plan easier to follow?

Examples include quick meals, batch cooking, leftovers, family meals, or more variety.

What would help you eat well when you're away from home?

Think about work, restaurants, travel, or times when you can't cook or refrigerate food.

Anything else you'd like us to know before we build your plan?