FOOD PREFERENCE CHECKLIST

Name of Client: _____

Date:_____ **Food Allergies:**_____

Likes:	**Dislikes:**
Special Diet?	**How much caffeine daily?**
Appetite?	**How much water daily?**
How well-balanced are the meals now?	**Daily Eating Routine:** **Number of meals and snacks/day**
Variety:	
Moderation:	
Favorite meal:	
Able to cook, prepare food?	
Food on hand:	
	Comments:

Person completing form_____