Nutrition Questionnaire

Date:

Please complete this form and bring to your appointment. If a question does not apply, leave it blank. This information will help your dietitian better understand your needs.

Name_____ Date of Birth _____

Address_____

City _____ Zip Code _____

Phone _____ Referring Physician _____

Email_____

Occupation _____

Reason for nutrition consult _____

Please check if you have or have had any of the following condition(s):

- ❑ high blood pressure
- ❑ diabetes
- ❑ arthritis
- ❑ gastrointestinal issues
- ❑ liver disease
- ❑ migraines
- ❑ high cholesterol
- ❑ prediabetes
- ❑ depression
- ❑ gall bladder disease
- ❑ cancer
- ❑ irritable bowel syndrome
- ❑ heart disease
- ❑ sleep apnea
- ❑ thyroid condition
- ❑ kidney disease
- ❑ eating disorder
- ❑ other _____

Height: _____ Weight: _____ Typical Blood Pressure _____

Most recent labs (date _____**)**

Total cholesterol _____ LDL _____ HDL _____ triglycerides _____

Glucose _____ C-reactive protein _____ Hemoglobin A1c _____

Other _____

FAMILY HISTORY

- ❑ high blood pressure
- ❑ alcoholism
- ❑ thyroid disorder
- ❑ heart disease
- ❑ osteoporosis
- ❑ other _____
- ❑ diabetes
- ❑ cancer (type): _____
- ❑ stroke

Food allergies/sensitivities_____

Current medications_____

_____

Dietary supplements_____

Do you <u>frequently</u> experience any of the following?

❑ diarrhea	❑ constipation	❑ bloating/gas
❑ dry skin	❑ heartburn or reflux	❑ light-headed or dizzy
❑ colds or flu	❑ water retention	❑ sinus problems
❑ headaches	❑ allergies	❑ mood swings
❑ muscle twitches	❑ PMS	❑ bleeding gums
❑ easy bruising	❑ canker sores	❑ tingling in fingers/toes

Check any that apply:

- ❑ My family eats most meals together.
- ❑ I eat most of my meals alone.
- ❑ Family meals are served at regular times on most days.
- ❑ Another member of my family is on a special diet or is trying to lose weight.

How many times in a typical week do you eat:

❑ Heat and serve meals _____ ❑ Home-cooked meals _____ ❑ Fast food _____
❑ Restaurant meals _____ ❑ Take out (grocery or restaurant) _____

How many hours do you sleep each night, on average? _____

What is the most important goal you want nutrition counseling to help you reach?

Do you have a support system to help you reach your goal(s)?

Are you…. ❑ very active ❑ somewhat active ❑ sedentary ❑ very sedentary

What types of exercise or physical activities you participate in *on a regular basis*?

Do you have any limitations for exercise/physical activity?

Using the following scales, please answer the following questions by placing an X on the line below:

1. How would you rate your nutrition knowledge?

……..

0	5	10
I don't know anything	I know the basics	I know a lot

2. How often do you think you eat healthy?

……..

0	5	10
I never eat healthy	I eat healthy a few times per week	I eat healthy daily

3. How important is making lifestyle changes, such as adjusting your diet or increasing your activity?

……..

0	5	10
not very important	somewhat important	very important

4. How ready you are right now to make lifestyle changes?

……..

0	5	10
not very ready	somewhat ready	very ready

5. How confident are you are that you can make lifestyle changes?

……..

0	5	10
not very confident	somewhat confident	very confident

6. How are your current stress levels?

……..

1	5	10
very relaxed	managing ok	very stressed

7. What lifestyle change(s) are you considering? _____

8. How much time are you willing to spend each week on making lifestyle changes? (for example, increasing activity, planning meals, journaling food) _____

9. What might get in your way of reaching your goal?

- ❑ lack of nutrition knowledge
- ❑ don't know how to cook
- ❑ lack of time/hectic schedule
- ❑ emotional or stress eating
- ❑ lack of organization
- ❑ don't like to cook
- ❑ other

If weight loss is a goal, please complete the box below.

1. Why is losing weight important for you? _____

2. What is a goal weight (or range) for you? _____
   How long ago were you at this weight? _____
   What weight (or weight range) would you consider acceptable? _____

3. What have you tried in the past to lose weight:

   - ❑ Diet(s): describe_____
   - ❑ Medication(s): list_____
   - ❑ Other methods: describe_____

4. If you have lost weight in the past:

   How much weight did you lose? _____ lbs. over _____ (time)

   How much of this weight, if any, did you gain back? _____lbs.

   What plan worked best for you and why? _____

5. Have you ever tried to lose weight with vomiting, diet pills, laxatives or not eating? ❑ No ❑ Yes

6. Do you often eat when bored, lonely or stressed or anxious? ❑ No ❑ Yes

7. Do you ever feel out of control when you eat? ❑ No ❑ Yes