FFR HEALTH
FIT FUELED RESOLUTE

2200 Elmwood Avenue Suite D11
Lafayette, Indiana 47904
(765) 756-5077
www.ffrhealth.com

Initial Nutrition Appointment Questionnaire

Name:_____ D.O.B_____Current Weight:_____

Height_____Age:_____ Sex:_____

Have you ever had a nutrition consultation? Yes/No

What do you hope to achieve in your visit?

List your three main health/nutrition concerns:
1)

2)

3)

Would you say you feel well/optimal? Yes/ No
If not, when was the last time you felt this way?

If you **do not** have a medical provider at FFR please list your current medical conditions, symptoms without an official diagnosis or diagnoses: (ex Crohn's disease, High blood pressure, Anemia, feel tired all the time):

If you **do NOT** have a medical provider at FFR please list all medications and supplements you are currently taking and the reason for taking them:

What Motivates you to change your eating habits? (Choose all that apply)

a. Want to lose weight
b. Want to look better in my clothes
c. Increase energy
d. Increase quality of life/health
e. Prevent disease
f. Other:

Have you tried to make changes to your diet in the past? Yes/No
Were you successful? Yes/No
If no, why not?

Do you currently follow a special diet or nutritional program (Keto, low carb, Paleo, Weight Watchers, Weight Loss Medications, etc)? Yes No (describe below)

Do you avoid any particular foods? Yes/No (describe below)

What are your favorite foods/ cuisines? List 3 or 4 maximum.

Do you have any cultural or religious factors that influence your food choices?

Do you have any food allergies or sensitivities? If yes, what are they?

Have you had any recent (within the past 4 months) history of weight loss or gain? (please describe)

If so, was it on purpose? Yes/No

Do you have (or had) an eating disorder? Yes/No (describe below)

How many meals per day do you eat?_____ How many snacks?_____

List a “typical day” of meals you eat and the times?
B-(a.m.)

L-(a.m./p.m.)

D-(p.m.)

Snacks-(a.m./p.m.)

Who does the cooking at home? _____

Who does the grocery shopping? _____

How many meals do you eat out per week? What is your favorite place to eat out?

Do you drink alcohol? Yes/No How many drinks per week?

Do you drink coffee or other caffeinated beverages? Yes/ No
How many drinks per day?_____

How often do you consume sugary drinks (flavored coffees, lemonade, sweet tea, energy drinks,etc)?_____

Do you use any artificial sweeteners? Yes/No (which ones?)

How much fruit do you eat per day?

How many vegetables do you eat per day?

How much water do you drink each day (cups or ounces)? _____

Check any that apply to your current eating habits:

Eat too much/overeat ___ Late night eating ___ Rely on convenience items ___ Love to eat ___

Love to cook ___ Time constraints ___ Eat fast food frequently ___

Poor snack choices ___ Do not plan meals or menus ___ Eat because I have to ___

Negative relationship with food ___ Eat for comfort_____ Eat out of boredom_____

Dislike healthy food ___ Travel Frequently ___
Trouble getting food (ex. Lack of transportation, can't afford food) ___

Trouble chewing, swallowing Yes/No

Nausea or vomiting after eating Yes/No

Do you experience any of the following if you haven't eaten in a while?:

a. Irritability
b. Lightheadedness
c. Weakness
d. Stomach aches
e. Other: _____

Gut Health and Elimination

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, Motrin, Aspirin)? Yes No

Have you had prolonged use of Tylenol? Yes/No

Have you had prolonged use of acid-blocking drugs (Zantac, etc)? Yes/No

Frequent antibiotics >3X per year? Yes/No Long term antibiotics? Yes/No

How often do you have bowel movements?_____

Circle the description(s) of the stool that best applies to you:

a. Fully formed, in one piece, brown colored
b. Any form, but a color other than brown
c. Soft, non formed
d. Separate lumps like pebbles or rocks
e. Liquid
f. Other:_____

Do you experience constipation or diarrhea? Yes/No If yes, How often_____

How often do you urinate in a 24 hour period_____

What is the condition of your skin and hair?

a. Very dry
b. Dry
c. Normal
d. Oil

Lifestyle

List the exercise that you participate in weekly:
Activity Type: Stretching/yoga Cardio/Aerobics Strength Training Sports or Leisure

Check the level of exercise that best fits you:

___Sedentary: Little to no exercise.
___Lightly Active: Light exercise a 1-3 times a week
___Moderately Active: Moderate exercise 3-5 days a week
___Very Active: Intense exercise or a physically demanding job 5-7 days a week

Note any problems that limit your physical activity:

Daily Stressors: (rate on a scale of 1 (low) to 10 (high) Work ____ Family _____ Social ____ Finances ___ Health ___ Other: _____

Average number of hours of sleep per night during the week:___ Average number of hours of sleep per night during the weekend:___

Trouble falling asleep? Yes/No Trouble Staying asleep? Yes/No

Do you wake up rested in the morning? Yes/No

If you wake up rested, do you experience energy crashes throughout the day? Yes/No. If yes, what part of the day (mid-morning, mid-afternoon, evening-before dinner)

Readiness

Readiness Assessment On a scale of 1 (not willing) to 5 (very willing) answer the following questions:

In order to improve your health how willing are you to:

___Significantly modify your diet
___Take nutritional supplements each day
___Keep a record of everything you eat each day
___Modify your lifestyle (sleep, work, exercise)
___Practice a relaxation technique
___Engage in regular exercise/physical activity
___Have periodic lab tests to assess your progress

Is there anything else you would like to share here or any question you have *related to nutrition*?