

Do you avoid any of the following foods? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Red meat | <input type="checkbox"/> Fruits | <input type="checkbox"/> Sweets (candy, desserts) |
| <input type="checkbox"/> Poultry (chicken, turkey) | <input type="checkbox"/> Fried food | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Breads | <input type="checkbox"/> Fats/oils (mayo, dressing, butter) |
| <input type="checkbox"/> Dairy (milk, cheese) | <input type="checkbox"/> Grains (pasta, rice) | |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Fast food | |

Foods you especially like: _____

Foods you especially dislike: _____

Weight History

Has your appetite changed recently? Y / N (Circle one)

If yes, please describe: _____

Have you recently gained or lost weight? If yes, please explain whether it was a gain or loss and what changes led to the change in weight. _____

Have you ever had concerns about your weight? Y / N (Circle one)

Underweight Overweight

Comment: _____

Have you ever tried to lose or gain weight in the past? Y / N (Circle one)

If yes, please describe: _____

Overall, how satisfied are you with the physical appearance of your body? (Check one)

- | | |
|---|--|
| <input type="checkbox"/> Very satisfied | <input type="checkbox"/> Somewhat dissatisfied |
| <input type="checkbox"/> Somewhat satisfied | <input type="checkbox"/> Very dissatisfied |

Physical Activity History

Are you currently physically active? Y / N (Circle one)

If yes, How often: _____ times per week

How long: _____ minutes per session

Type of activities: _____

Please rate the average intensity of your workouts: (Circle one)

- | | |
|----------|---|
| Light | (walking slowly, sitting, standing) |
| Moderate | (walking briskly, heavy cleaning, light bicycling) |
| Vigorous | (hiking, running, fast bicycling, most team sports, weight lifting) |

Nutrition Goals

What nutrition-related goals do you have? What eating habits would you like to work on?

How important is it to you to make changes in your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant

Very Important

How confident are you in your ability to improve your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant

Very Important