Nutrition and Health Information Questionnaire

Please fill out this form to the best of your ability. The more detail you provide, the more we can tailor our time together to meet your individual nutrition needs and goals. All responses are confidential. Please come prepared to describe your eating patterns over the past 24 hours.

| Name: | | | | | Date: | | | | | |
|--------------------------------------------|--------------|--------------|-------------|-------------|------------|-------------|-------------|-------------------|--|--|
| Age: | Hei | ght: | | Weight | : | Gen | Gender: | | | |
| Primary Reason | for Visit: _ | | | | | | | | | |
| How did you hea | ar of us: | | | | | | | | | |
| Medical/Health Please list any p | | ent medica | l conditio | ons that yo | ou have or | are current | tly being t | reated for: | | |
| List any medicat | ions you a | are currentl | y taking: | | | | | | | |
| Do you have any If yes, please list | | _ | • | _ | | | N (Circle | e one) | | |
| Do you take any If yes, please list | | | | | | | N (Circle | e one) | | |
| Do you smoke? | Y / N (0 | Circle one) | If yes, h | ow often/ | how much | ı: | | | | |
| Do you drink alc | ohol? Y / | N (Circle | one) If | yes, how | often/how | much: | | | | |
| Please rate your | daily stre | ss level: | | | | | | | | |
| 1 2 Low Stress | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 High Stress | | |
| How do you cop | e with str | ess in your | daily life? | · | | | | | | |
| Food & Nutritio How many time | | you typical | lly eat: | | | | | | | |
| Do you consume | | _ | | _ | · · | | • • | rs | | |

| Do you avoid any of the followin | g foods? (Check all that apply) | |
|---------------------------------------|----------------------------------------------|---------------------------------------|
| Red meat | Fruits | Sweets (candy, desserts) |
| Poultry (chicken, turkey) | Fried food | Alcohol |
| Fish | Breads | Fats/oils (mayo, dressing, butter) |
| Dairy (milk, cheese) | Grains (pasta, rice) | |
| Vegetables | Fast food | |
| Foods you especially like: | | |
| Foods you especially dislike: | | |
| Weight History | | |
| Has your appetite changed rece | ntly? Y / N (Circle one) | |
| If yes, please describe: | | |
| | | |
| | t weight? If yes, please explain wight. | hether it was a gain or loss and what |
| | | |
| | | |
| Underweight | out your weight? Y / N (Circle Overweight | |
| | | |
| | nin weight in the past? Y / N (0 | |
| if yes, please describe: | | |
| | | |
| Overall, how satisfied are you w | ith the physical appearance of yo | our body? (Check one) |
| Very satisfied | Somewhat dissatis | ified |
| Somewhat satisfied | Very dissatisfied | |
| Physical Activity History | | |
| Are you currently physically activity | ve? Y / N (Circle one) | |
| If yes, How often: | | |
| | minutes per session | |
| | :niinutes per session | |
| | | |
| Please rate the average intensity | | • |
| _ | (walking slowly, sitting, standing | |
| Moderate | (walking briskly, heavy cleaning, | |
| Vigorous | (hiking, running, fast bicycling, m | nost team sports, weight lifting) |

Nutrition Goals

| wnat | what nutrition-related goals do you have? What eating habits would you like to work on? | | | | | | | | | |
|-------------|-----------------------------------------------------------------------------------------|--------------|-------------|------------|------------|-------------|-------------|------------|------------|-------------|
| How | important | is it to you | u to make o | changes in | your nutr | ition habit | :s? (Please | circle) | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| Unim | portant | | | | | | | | Very Impor | tant |
| How | confident a | are you in | your abilit | y to impro | ve your ni | utrition ha | bits? (Plea | se circle) | | |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
| Unimportant | | | | | | | | Very Impor | tant | |