

Nutrition Intake Questionnaire

Name: _____ Today's Date: _____

Date of Birth: _____

What brings you to the nutrition clinic today? _____

Have you been told to follow any diet restrictions? ____ yes ____ no

If yes, please check all restrictions that apply to you.

____ low calorie ____ low cholesterol ____ low/salt/sodium ____ low protein

____ low fat ____ high fiber ____ other: _____

If the dietitian recommends a change in your current eating habits, would this be difficult?

____ yes ____ no If yes, why? _____

Have you seen a dietitian or received nutrition counseling prior to today? ____ yes ____ no

What eating concerns do you have? _____

HISTORY

What is your highest level of education? (Please circle one.)

Grade School

High School

College

Advanced Degree

Do you or your family have any of the following medical conditions?

(Circle all that apply & indicate self and/or specify family member.)

Diabetes

Stroke

IBS

Cancer

Mild/Chronic Depression

Heart Disease

Crohn's Disease

(Type: _____)

Mild to Moderate Anxiety

High Blood Pressure

Ulcerative Colitis

Menstrual Problems

Insomnia

High Cholesterol

Diverticulitis/-osis

Menopause

Overweight/Obesity

High Triglycerides

Food Allergy/Intolerance

Other _____

Family member with heart

(Type: _____)

disease prior to age 50

Do you drink alcohol? YES/NO (beer / wine / liquor) How often? _____ How much? _____

Do you consume caffeine? YES/NO (coffee / tea / soda) How often? _____ How much? _____

Do you smoke? YES/NO (cigarettes / cigars / marijuana)

How many packs per day? ____ How many years? ____ Year Quit? _____

Do you use recreational drugs? YES/NO (Please specify: _____)

Do you take vitamins or any other nutrition supplement? YES/NO If yes, please describe:

Name or type

Dose (if known)

How often

Do you take medications (prescription, over the counter, etc)? YES/NO If yes, please describe:

Name or type

Dose (if known)

How often

WEIGHT

Has your weight changed in the last year? YES/NO

If yes, describe the change. _____

What is your height? _____

What is your usual weight? _____

What would you like to weigh? _____ How often do you weigh yourself? _____

What has been your highest weight? _____ At what age? _____

What has been your lowest (adult) weight? _____ At what age? _____

If you now weigh less than your highest weight, how did you lose the weight? _____

LIFESTYLE/EATING

Are you currently working? YES/NO What do you do? _____

What are your usual work hours? _____

Rate your appetite: ___ good ___ fair ___ poor

Do you have any eating or digestion problems? YES/NO

___ chewing ___ swallowing ___ stomachache ___ nausea

___ constipation ___ diarrhea ___ other: _____

Are you a fast/medium/slow eater? _____ How long do your meals last? _____

What is your usual schedule? What do you eat/drink in a typical day (or did you consume in the last 24hrs)?

Morning or 1st Meal

Time _____

Location _____

Snack

Time _____

Location _____

Afternoon or 2nd Meal

Time _____

Location _____

Snack

Time _____

Location _____

Evening or 3rd Meal

Time _____

Location _____

Snack

Time _____

Location _____

How many times a week do you eat the following foods?

regular soda pop _____ x/week

ice cream/other frozen desserts _____ x/week

sweet roll/pastries _____ x/week

cookies _____ x/week

candy, candy bars _____ x/week

other _____ x/week

desserts - pie, cake _____ x/week

Who lives in your household with you? _____
Is everyone in the household in good health? YES/NO (Explain: _____)
Who prepares the meals? ___ self ___ spouse ___ roommate ___ other (who? _____)
Are there any special considerations in family meal planning? _____

How often do you eat in restaurants, cafeterias or away from home?
Breakfast ___ x/week Lunch ___ x/week Dinner ___ x/week
What type of restaurant? _____

How often do you eat prepackaged foods, take-out or frozen meals from grocery or restaurant?
Breakfast ___ x/week Lunch ___ x/week Dinner ___ x/week

ACTIVITY

Do you exercise now? YES/NO
If yes, what do you do? _____ How frequently? ___ x/week
If no, what exercise would you consider? ___ walking ___ exercise class ___ Other: _____

Do you have any limitations on exercise? YES/NO
If yes, please describe. _____

What would you like to know more about?
___ weight loss ___ exercise
___ eating out ___ label reading
___ alcohol use ___ sweeteners
___ other: _____

What do you hope to accomplish or gain from this appointment?
I would like to:
___ improve blood glucose ___ get more information
___ improve eating habits ___ start exercising
___ lose weight ___ lower cholesterol/triglycerides
___ feel better ___ other: _____

IF YOU HAVE ELEVATED BLOOD SUGAR, PRE-DIABETES, OR DIABETES, COMPLETE THE FOLLOWING:

When were you first told you had diabetes? _____
Have you had previous instruction on diet? YES/NO
If yes, who provided the instruction? _____
When was this done? _____

Do you have a meal plan? YES/NO
If yes, how many calories or carbohydrates? _____
How much of the time are you able to follow it?
0% 25% 50% 75% 100%

Do you check your blood sugar with a glucometer? YES/NO
What is the name of your glucometer? _____ Do you keep a log? _____
How often do you check?: _____ Fasting? Bedtime? Before Meals? After Meals?