NUTRITION QUESTIONNAIRE

Name: ___________________________________ **Age:** ______ **Date:** __________________

Are following any special diets at the current time? (low fat, vegetarian, low calorie, low carb, diabetic, allergy, etc.) ____

What would you like to learn about nutrition while under our care, or do you have any nutritional goals ? ____

____

When and how do you think your eating issues began? ________________________

____

____

Height: ______ **Weight:** _______ **Highest Weight:** _______ **When:** _______________

Lowest Weight: _______ **When:** ___________________ **Comfortable Weight:** _______

Have you been able to maintain "your comfortable weight" for any period of time?

❑ **Yes** ❑ **No** If yes, how long? _____________

How often do you weigh yourself? ____

When was your last physical? ____

Have you ever had any abnormal bloodwork results? ☐ **Yes** ☐ **No**

If yes, please list abnormal tests: ____

Do you have any significant family medical history? ☐ **Yes** ☐ **No**

If yes, please list here: ____

Check any of the following medical/physical issues that currently apply to you:

❑ Low energy levels ❑ Bloating/edema ❑ Constipation ❑ Fatigue
❑ Diarrhea ❑ Dental Problems ❑ Insomnia ❑ Hair Loss
❑ Reflux ❑ Gas ❑ Headaches ❑ Light-headedness
❑ Cold sensitivity ❑ Bruise easily ❑ Muscle cramps
❑ Hypoglycemia (low blood sugar) ❑ Diabetes (high blood sugar)

Please list any other medical or psychiatric issues or diagnoses that may have nutritional implications on your health (immune problems, hormone, previous cancers, depression, anxiety, obsessive compulsive issues, etc.):

____

____

Developed by Page Love, MS, RD, CSSD, LD ♦ © Nutrifit, Sport, Therapy, Inc. ♦ www.nutrifitga.com

Females Only – next 4 questions

Have you started menstruation? ❑ **Yes** ❑ **No**

If yes, at what weight approximately did you start menstruating? ______ lbs.

Are your menstrual cycles normal or regular? ❑ **Yes** ❑ **No**

Have your menstrual cycles ever been irregular? ❑ **Yes** ❑ **No** Explain: ____________

Do you currently take any nutritional supplements including vitamins, minerals, herbals (e.g., ginsing, MaHuang, ginko) or food supplements (e.g., Ensure, Boost, weight gain powders)? ❑ **Yes** ❑ **No** If yes, please list types: ____________________________

Do you take any medicines on a regular basis? Please list: ______________________

____

Have you ever or are you currently participating in the following behaviors?

	Last time	**How often**
Binging ❑ **Yes** ❑ **No**	________	_____x/wk
Vomiting after eating ❑ **Yes** ❑ **No**	________	_____x/wk

Restricting calories ❑ **Yes** ❑ **No** What calorie level do you adhere to? _________

Restricting/limiting certain foods/food groups? ❑ **Yes** ❑ **No**

Which foods are you currently restricting? _____________________________________

Would you consider yourself and emotional eater? ❑ **Yes** ❑ **No**

Do you currently use any diet, low-fat or fat-free foods or condiments (milk, frozen desserts; condiments – margarine, cream cheese, or salad dressing)? ❑ **Yes** ❑ **No**

If yes, please list: ____

Do you have any other foods which you would consider fear foods or foods that you have completely eliminated out of your diet? _______________________________________

____

Are there any other foods that you limit because of allergies, religious reasons, or have never liked? ❑ **Yes** ❑ **No** If yes, describe what foods and reasons why: _____________

____

Laxative (or enema) abuse? ❑ **Yes** ❑ **No** Last use: ____________ How many times per week? _____________ What type?____

Do you (over-)exercise? ❑ **Yes** ❑ **No** Last time: __________ Type: ______________

If no, are you currently exercising? ❑ **Yes** ❑ **No**

If yes, describe your workout routine: ____

____

Use of diet pills (or diuretics)? ❑ **Yes** ❑ **No** Last Use: ______ How often: ______x/wk

Parents' marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Your current living situation: ❑ Alone ❑ With parents ❑ With spouse ❑ With friend(s) ❑ With roommate(s) ❑ With sibling(s)

Who does most of the grocery shopping? ____________________________________

Who does most of the cooking? ____

Do you like to shop for groceries? ____

Do you like to cook? ____

Would you like to cook more? ____

How many times per week do you normally dine out? _________________________

What types of restaurants do you go to and what entrée choices do you normally make? ____

Do you struggle with shopping, cooking, or dining out? ❑ **Yes** ❑ **No** Describe:

____

Do any family members have weight issues? (obesity, eating disorders) ❑ **Yes** ❑ **No**

If yes, who?____ If yes, did this influence your eating in any way? ____

Does your family sit down for family meals? ❑ **Yes** ❑ **No**

Have you ever seen a Dietitian or Nutritionist before? ❑ **Yes** ❑ **No** When? ________

How often? ___________________

Do you still see this person? ❑ **Yes** ❑ **No** Name:______________________________

Phone Number of Dietitian/Nutritionist: ____

Would you give permission for us to contact your previous RD? ❑ **Yes** ❑ **No**

Please list what would be normal for you to eat on a typical day. Please be sure to list all the foods, beverages, condiments and the approximate amount of each.

	Breakfast	Lunch	Dinner	Snacks
Fruit				
Veg				
Dairy				
Grain				
Meat				
Fat				
Beverages				
Condiments				

Please provide any other information regarding your eating habits that you feel we should be aware of in order to provide you with optimum nutritional care (e.g., any food fears or rituals you would like to have addressed while you are here: ______________________________

____