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Nutrition Questionnaire

Name			Date
Date of Birth		Age:	Gender: ☐ F ☐M
Primary Address			
City, State, Zip Code			
Primary Phone			☐ Home ☐Cell ☐ Work
Secondary Phone			☐ Home ☐Cell ☐ Work
E-mail Address			*Approved to e-mail personal info?* ☐ Yes ☐No
Best way to contact?	☐ Email ☐Phone, *approved to leave a message?* ☐ Yes ☐No		
Primary Physician	*Name:*		*Clinic:*
	Address:		*Phone:*
Other Provider	*Name:*		*Clinic:*
	Address:		*Phone:*

Referred by: _____

Biometrics & Lab Results

Biometric / Lab	**Result**	**Date**
Height		
Weight		
Blood Glucose		
Hemoglobin A1c		
Total Cholesterol		
LDL Cholesterol		
HDL Cholesterol		
Triglycerides		
Blood Pressure		
TSH		

Medications & Supplements

Please list all medications, nutritional supplements, and herbs/botanicals (use separate sheet if needed).

Medication Name	Dose	Frequency	Reason

Supplement Name	Dose	Frequency	Reason

Surgeries & Hospitalizations

Please list any previous injuries, surgeries and hospitalizations (provide date & your age, if known)

Family History

Please note any family history of the following: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, mental health or addiction

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Family Member: _____ Health Condition: _____

Personal Medical History relevant to Nutritional Health (please check all that apply)

Gastro-intestinal

- ☐ Celiac disease
- ☐ Crohn's disease
- ☐ Diverticular disease
- ☐ Gastric reflux disease
- ☐ Irritable bowel (IBS)
- ☐ Lactose intolerance
- ☐ Ulcerative Colitis
- ☐ Gastric or peptic ulcer

Respiratory/Pulmonary

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sleep apnea
- ☐ Tuberculosis

Hematology / Blood

- ☐ Anemia: Type _____
- ☐ Bleeding disorder
- ☐ Thalassemia

Hepatic / Pancreatic

- ☐ Cirrhosis
- ☐ Gallbladder disease
- ☐ Hepatitis
- ☐ Pancreatitis

Renal

- ☐ Chronic kidney disease
- ☐ Dialysis
- ☐ Kidney failure
- ☐ Kidney stones
- ☐ Nephritis

Urinary

- ☐ Incontinence
- ☐ Urinary Tract Infections

Cancer

- ☐ Type: _____
- ☐ Type: _____
- ☐ Type: _____

Cardiovascular

- ☐ Angina/chest pain
- ☐ Cardiovascular disease
- ☐ Heart valve disease
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Peripheral artery disease
- ☐ Stroke

Metabolic / Endocrine

- ☐ Metabolic syndrome
- ☐ Pre-diabetes
- ☐ Diabetes: Type _____
- ☐ Hypoglycemia
- ☐ Polycystic ovary disease
- ☐ Infertility
- ☐ Thyroid disease

For females

- ☐ Currently pregnant
- ☐ Irregular / No periods
- ☐ Gestational Diabetes
- ☐ Peri-menopausal
- ☐ Post-menopausal

Inflammatory / Autoimmune

- ☐ Chronic fatigue
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Lupus SLE
- ☐ Rheumatoid Arthritis

Musculo-skeletal

- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Osteoarthritis

Neurological

- ☐ Addiction
- ☐ ADD/ADHD
- ☐ Anxiety
- ☐ Autism
- ☐ Depression
- ☐ Headaches
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Sleep difficulties

Eating Disorder

- ☐ Anorexia
- ☐ Binge eating
- ☐ Bulimia
- ☐ Compulsive overeating
- ☐ Other: _____

Dermatological

- ☐ Acne
- ☐ Eczema
- ☐ Rosacea
- ☐ Skin rashes

Other: _____

Other: _____

Allergies

- ☐ Foods_____
  _____
  _____
  _____
  Medications_____
  _____
  _____
  _____
- ☐ Environmental_____
  _____
  _____
  _____

Nutrition History

Have you made any changes in your eating habits because of your health? ☐ Yes ☐No
Please describe:

Do you currently follow a special diet or nutritional program? ☐ Yes ☐No
Please describe:

Do you avoid any particular foods? ☐ Yes ☐No
Please describe:

Have you had any recent history of weight loss or weight gain? ☐ Yes ☐No
Please describe:

Do you have any adverse food reactions (allergies or intolerances?) ☐ Yes ☐No
Please describe:

Current Meal Preparation and Eating Habits

Who purchases food for your home?	
Where do you purchase food? *Please list:*	
Who prepares meals at home?	
How many meals per day do you eat?	How many snacks?
How many meals do you eat out per week? ☐ 0-1 ☐1-3 ☐ 3-5 ☐ more than 5	
Do you drink alcohol? ☐ Yes ☐No	*If yes, how many drinks per week?*
Do you drink coffee or other caffeinated beverages? ☐ Yes ☐No	*If yes, what type and how many drinks per day?*
Do you use any natural or artificial sweeteners? ☐ Yes ☐No	*If yes, which ones?*

Current Eating Habits

Please check all the factors that apply to your current eating habits:

- ☐ Love to eat
- ☐ Love to cook
- ☐ Fast eater
- ☐ Erratic eating patterns
- ☐ Family members have different tastes
- ☐ Rely on convenience
- ☐ Eat fast food frequently
- ☐ Poor snack choices
- ☐ Do not plan meals
- ☐ Time constraints
- ☐ Travel frequently
- ☐ Emotional eater
- ☐ Eat too much / overeat
- ☐ Late night eating
- ☐ Live or often eats alone
- ☐ Struggle with eating issues
- ☐ Eat because I have to
- ☐ Negative relationship with food
- ☐ Dislike healthy food
- ☐ Confused about food/nutrition

Please note any additional comments about your lifestyle / eating habits:

Physical Movement

Do you engage in moderate cardiovascular physical activity for a minimum of 20 minutes at least 3 days a week? *For example: brisk walking, jogging, hiking, cardio exercise classes, cycling?*	☐ Yes ☐No

Activity	**Type / Intensity**	**# Days per Week**	**Duration (minutes)**
Stretching / Yoga			
Cardio / Aerobics			
Strength Training			
Sports or Leisure			

Please note any problems that limit your physical activity

Social / Personal History

Marital Status	☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Widowed
Children ☐ Yes ☐No	*If yes, number of children?*____ *Ages?*_____
How many live in your household?	*Number of adults:* _____ *Number of adults:* _____

Stress Management

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)* ☐ Work _____ ☐ Family _____ ☐ Social _____ ☐ Finances _____ ☐ Health _____ ☐ Other _____	
Excess stress in your life? ☐ Yes ☐ No	Do you easily handle stress? ☐ Yes ☐ No
How do you handle stress, what nourishes you?	
Do you believe stress is presently reducing the quality of your life? ☐ Yes ☐ No	

Sleep

Average number of hours you sleep per night during the week? ☐ <6 hours ☐ 6 to 8 hours ☐ 8 to 10 hours ☐ 10 or more hours	
Average number of hours you sleep per night on the weekends? ☐ <6 hours ☐ 6 to 8 hours ☐ 8 to 10 hours ☐ 10 or more hours	
Trouble falling asleep? ☐ Yes ☐ No	Rested upon waking? ☐ Yes ☐ No
Do you wake up during the night? ☐ Yes ☐ No *If yes, how many times?*	
How would you rate the overall quality of sleep? ☐ 1 *Low* ☐ 2 ☐ 3 ☐ 4 ☐ 5 *High*	

Smoking

Do you drink smoke? ☐ Yes ☐No Secondhand smoke? ☐ Yes ☐No	*If yes, how many years?*_____ *Packs per day?*____ *If yes, how many years?*_____

Readiness Assessment

In order to improve your health, how willing are you to: Rate on a scale of 5 (very willing) to 1 (not willing)

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (*work demands, sleep habits, exercise*)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation or mindfulness technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise / physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Personal Goals

What do you hope to achieve in your nutrition consult?

If you alleviate three problems, what would they be?
List your three main health / nutrition concerns:

1.

2.

3.

When was the last time you felt well?

Did something trigger your change in health?

What makes you feel better?

3-Day Food Journal

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete the attached food journal for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food records is to analyze your present eating habits
- Record information as soon as possible after the food has been consumed
- Please describe all foods and beverages consumed as accurately and in as much detail as possible including estimated amounts, brand names, cooking method, etc.
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items, for example: tea with1 tsp. honey, potato with 2 tsp. butter, etc.
- List all beverages and types, including water, coffee, tea, sports drinks, sodas/ diet sodas, etc.
- Please comment on any noted emotional or physical symptoms including hunger level, stress, bloating, fatigue, adverse reaction experienced, etc.
- Include comments about eating habits and environment such as reasons for skipping a meal, when a meal was eaten at a restaurant, etc. and any additional details that may be important
- If desired an online food journal may be kept at myfitnesspal.com, please provide me with your login information

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Food Journal for Day 1

Meal or snack	Time of day	Food and Beverages Please include portions / amounts eaten	Comments or Symptoms
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

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Food Journal for Day 2

Meal or snack	Time of day	Food and Beverages Please include portions / amounts eaten	Comments or Symptoms
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			

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Food Journal for Day 3

Meal or snack	Time of day	Food and Beverages Please include portions / amounts eaten	Comments or Symptoms
Breakfast			
Morning Snack			
Lunch			
Afternoon Snack			
Dinner			
Evening Snack			
Overnight Snack			