Nutrition and Health History Questionnaire

Part I. General Information

Evaluation Date_________________________________

Name____

Age__________________ Height_____________________ Weight_________________________

What are your wellness/nutrition goals? (check all that apply)

_______ Feel better overall, improve metabolism

_______ Improve nutritional habits (e.g., eat fewer sweets, eat more vegetables, control portions)

_______ Develop better lifestyle skills (e.g., plan meals, make smart food choices)

_______ Lose weight (If checked, include weight loss goal :_______________)

_______ Lower cholesterol

_______ Improve high blood pressure

_______ Improve blood glucose (sugar) levels

_______ Reduce stress

_______ Improve cardiovascular fitness

_______ Improve muscle strength and conditioning

_______ Other (please specify)____

Have you seen a dietician/nutritionist in the past? _______No _______Yes

If yes, how long ago and for what condition?

____

____

Was it resolved? _______No ________Yes

Part II. Medical History

Do you have, or have you ever had, any of the following medical conditions?

______ Arthritis	______ Diabetes	______ Cancer
______ Heart Disease	______ High Blood Pressure	______ High Cholesterol
______ Lung Disease	______ Stomach or GI Problems	______ Stroke
______ Autoimmune Disease	______ Liver Disease	______ Organ Removal
______ Cancer	______ Thyroid Problems	______ Anxiety

Do you have any other medical conditions not mentioned above? ________No ________Yes

(If yes, please explain:____
____
____
____

Please list any medications that you are taking:

Name	Dosage	Reason

Are you taking a multi-vitamin and/or any other supplement(s)?

Name	Dosage

Do you smoke? __________No ___________Yes Cigarettes/day___________ Cigars/day___________

Do you drink alcoholic beverages? _________No __________Yes

If yes, how many drinks per week? ____

(Note: one drink equals 1.5oz of hard liquor, 4-5oz of wine, or 12 oz. beer)

Which best describes the amount and type of stress you experience on a daily basis:

_________ No stress _________ Occasional mild stress _________ Frequent mild stress

_________ Frequent moderate stress _________ Frequent high stress

_________ Constant Stress (from mild, moderate, to severe)

Do you have any sleep problems? ________No ________Yes

If yes, please explain____
____
____
____
____

Part III. Weight History

Have you gained or lost weight in the last year? ________No _________Yes

If yes, please indicate the amount of weight change:

_____________ Pounds Lost _____________ Pounds Gained

What do you think is a realistic goal weight for you? _______________.

When was the last time you weighed the goal weight? ____________________________.

What happened between then and now to cause the weight change?

____
____

Have you ever followed a diet to lose weight? __________No ___________ Yes

If yes, what has been your preferred way of dieting?

_______ Skip meals _______ Fasting (juicing, no food intake) _______ Restricting calories

_______ Restricting carbohydrates _______ Restricting fats _______ Reducing portions

_______ Go on fad diets (e.g., Atkins, Zone) _______ Other: ___________________________________

When dieting in the past, what were your most and least successful attempts to lose weight (if applicable)?

Most successful -

Least successful -

What barriers to success do you anticipate (time constraints, discipline, lack of support, etc.)?
____
____

Do you have support from family and friends (if applicable)? _______No _______Yes

Part IV. Diet History

Are you now, or have you ever been, on a special diet? _______No _______Yes
(e.g., low calorie, diabetic, low sodium, low fat, low cholesterol, high fiber, vegetarian)

If yes, what type of diet is/was it:_______________________________________(Self or M.D. Prescribed)

Do you have any known food sensitivity or food allergies? ______No ______Yes

If yes, which foods____
____
____

Do you consume fast food? ________No ________Yes (times per week _______)

If yes, where do you go and what do you currently order off the menu?
____
____
____

Do you eat out at Restaurants? ________No ________Yes (times per week________)

If yes, where do you go and what do you currently order off of the menu?
____
____
____

Where do you shop for groceries?
____
____

What are your favorite foods? What foods do you crave?
____
____
____

Do you find yourself eating when: (check all that apply)

________ Bored	_________ late at night	_________ increased stress
________ anxiety	_________ depressed	_________ constantly hungry

How many meals and snacks do you eat a day? ____

Please write down a sample of what you eat in one day (specify the time and amount of food at each meal or snack)

Breakfast
Lunch

Dinner
Snack(s)

Part V. Exercise History

Do you have any physical problems that cause you to limit your physical activity?
________ No
________Yes (please explain)____
____
____

<u>Workout Routine:</u> Please provide the time of day you exercise, the type of exercise (e.g., cardio, strength training, yoga, stretching, etc.), and how you exercise. (Please be specific as this will directly affect your meal plan).

Day	Time of day	Type of exercise	Duration
Monday			
Tuesday			
Wednesday			

Thursday			
Friday			
Saturday			
Sunday			