Nutrition Questionnaire

A. Personal Data

Date:________________
Name____ ID #____________________
Birth date:________________

Age_________ Ht_________ Wt_________ Gender: Male / Female

Year in School:
1) Freshman
2) Sophomore
3) Junior
4) Senior

Major:___________________________________

B. Nutritional Status

Why do you want nutrition counseling at this time?
____
____

Has your weight changed within the last year?
□ no change □increase □ decrease □ fluctuates □ do not know

What was/is the reason for the weight change, if applicable?
____
____

What do you think is a realistic weight for you? ______________ pounds

C. Daily Routines

Number of meals per day?_________________________

Number of snacks per day?________________________

Please list all food/beverages consumed in the last 24 hours:

	Time	What did you eat/drink ? (please specify amounts as accurately as possible)	Location
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			

Is this a typical day for you?

___

D. Diet History

1. Who prepares your meals?

2. List some of your favorite foods. How often do you eat them?

3. List restaurants you often eat at:

____
____
____
____

4. Are you allergic to any foods? □ Yes □ No
   If so, which foods?

5. Do you currently take any medications? □ Yes □ No
   If so, which one(s)?

6. Do you use any other dietary supplements? □ Yes □ No
   (for example herbs, garlic pills, fish oil, fiber powder, etc)?
   If so, which one(s)?

7. Have you ever followed a special diet? □ Yes □ No
   (For wt loss or one prescribed by your doctor)
   Please specify which one(s):

E. Physical Activity

Do you exercise? No___________ Yes___________

If you do exercise, what do you do? How often?

____

Is there any reason preventing you from exercising?

____

E. General Health

1. Do you smoke cigarettes? (circle) Yes No
   If so, how often?____

2. Do you consume alcoholic beverages? (circle) Yes No
   If so, how many beverages do you consume per day?_________________________

   Do you binge drink? (circle) Yes No

   Are you an occasional drinker (holidays, birthdays, etc.)? (circle) Yes No

Is there anything else you would like the dietitian to know?

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____
____
____