Nutrition and Health Questionnaire

Date_____

Name_____ Pronouns_____ Age_____

Medical History: Have you ever had, or do you presently have, any of the following conditions?

List year:	Yes	No
_____ high blood cholesterol	□	□
_____ high/low blood pressure	□	□
_____ heart attach/stroke	□	□
_____ weight concerns	□	□
_____ diabetes/high blood sugar	□	□
_____ alcohol and/or drug abuse	□	□
_____ eating disorder, please specify type_____	□	□
_____ depression/anxiety	□	□
_____ gastrointestinal problems	□	□
_____ osteopenia/osteoporosis	□	□
_____ other_____	□	□

Does anyone in your family have any medical or mental health conditions? Yes No
If yes, please list family member and condition.
_____ □ □

Are you taking any medications, including over-the-counter drugs (such as aspirin, antacids, diet pills, laxatives, etc.)? If yes, please identify.
_____ □ □

Are you taking any supplemental vitamins, minerals, herbs, or other dietary supplements? If yes, please identify.
_____ □ □

Do you have any food allergies or food intolerances? If yes, please identify.
_____ □ □

Do you have any problems with constipation? □ □
Do you have any problems with diarrhea? □ □

Do you have irregular periods/menstrual cycle? If yes, please describe. □ □
_____
Are you currently taking oral contraceptives/birth control or any other hormone? □ □
_____

Lifestyle Profile

Do you currently smoke? □Yes □No Do you currently exercise? □Yes □No
Describe types of exercise_____
How many days/week?_____ How long per session?_____

How stressful do you consider your life right now? (circle)
1 (not stressful at all) 2 3 4 5 (extremely stressful)

How is your food intake/tolerance affected by stress or emotions? (check all that apply)
□No effect □eat more □eat less □irritable bowel/diarrhea □other_____

Weight History

What is your height?_____ What is your weight? _____ (if unsure, please estimate)
Have you had any recent change in weight? □Yes □No
If yes, please explain_____
What is your highest weight? _____ Age/year?_____
What is your lowest weight? (if adult, lowest wt in adulthood)_____ Age/year?_____
How do you presently think of yourself? (check one)
□underweight □at your normal weight □moderately overweight □very overweight
If you would like to gain or lose weight, what would you like to weigh?_____
Do you weigh yourself? □Yes □No If yes, how often?_____

Nutrition Patterns

Are you following a special diet at this time? □Yes □No
If yes, please describe_____

Are there any foods that you avoid? □Yes □No
If yes, which ones_____

Where do you prepare/purchase/eat most of your meals? (check all that apply)
□Home □Fast food □Sit down restaurant □Cafeteria □Vending machine □Car
Do you cook/prepare your own meals? □Yes □No
Do you primarily eat alone or with others?_____

Do you read food labels? If yes, what information on the food label are you focusing on?
_____
Do you weigh or measure your foods? If yes, please explain_____
_____

Please describe your usual daily eating pattern.

Time	Food/beverage (estimate amount eaten)	Location
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Typical fluid consumption throughout the day (please indicate in ounces); may list frequency:
Water_____ Coffee_____ Tea_____ Juice_____ Soda_____ Milk_____
Alcohol_____ Other_____

What specific goals do you want to achieve through nutrition therapy?
_____
_____