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NUTRITION and HEALTH QUESTIONNAIRE

Name _____

Address _____

_____

Phone Number _____

Date of Birth _____ Age _____ Sex M or F

Email _____

Reason for visit/nutrition goals _____

Past Medical History

Health concerns and medical diagnosis (include onset dates)_____

_____

Medications (prescribed and over the counter) _____

_____

Supplements (vitamin, mineral, herbal, nutritional) _____

_____

Date of last physical exam _____

Recent lab results (if known) _____

Primary Care Physician _____ Phone Number _____

Specialist _____ Phone Number _____

Family History

Disease	Family Member
○ Heart Disease	_____
○ High Blood Pressure	_____
○ Diabetes	_____
○ Obesity	_____
○ Stroke	_____
○ OB (high risk)	_____
○ Cancer	_____
○ Thyroid	_____
○ High Triglycerides	_____
○ Other	_____

Weight History

Height _____ Current Weight _____

What was your:

Lowest adult weight (over 21) and age at that weight? _____

Highest adult weight (over 21) and age at that weight? _____

Usual weight (for the past 6-12 months)? _____

Have you ever been on a diet in the past? _____

How long were you on the diet(s)? _____

Food Intake Questions

1. How would you generally describe your eating habits? Good Fair Poor
2. Has your appetite changed recently? Yes No
3. How many times a day do you eat? _____
4. How long does it usually take to complete a meal? _____
5. Do you have any GI problems? (heartburn, nausea, diarrhea, constipation) _____
6. Do you have any problems chewing or swallowing? Yes No

7. How often do you eat out? _____
8. What types of restaurants? _____
9. Who prepares food/food shopping? _____
10. Do you enjoy food shopping? _____
11. Do you enjoy cooking? _____
12. Do you currently use tobacco products? _____

    If so, how frequently? _____
13. Do you drink alcoholic beverages? _____

    If so, how frequently? _____
14. Do you have a history of taking diet pills or laxatives? _____

Intuitive Eating Intake

Do you feel hunger? _____

Do you feel fullness? _____

Do you find yourself eating when you are – Emotional Bored Stressed N/A

Do you find yourself restricting yourself in any way?_____

a. If so, how?_____

Do you avoid certain foods?_____

For example, high fat, carbs, etc.

What do you consider healthy eating?_____

Did your parents have rules for eating family meals? _____

a. Were you expected to clean your plate?_____
b. Were you not allowed to have dessert or fast food?_____

As a child, did you ever sneak food that was considered unhealthy?_____

Do you feel guilty after eating certain foods?_____

a. If so, which foods_____
b. If so, how do handle the guilt?_____

Do you typically engage in other activities while eating? Such as working at desk, watching TV, eating while driving?_____

Do you eat differently if there are other people present?_____

Do you compare what you eat to other people?_____

Do you usually describe a day of eating as “good or bad”?_____

Was there a lot of pressure about your weight while growing up?_____

How often do you weigh yourself?_____

Activity Level

List physical activities and frequency _____

_____

_____

How well do you sleep at night? 1 (Poorly) – 5 (Great) _____

How many hours do you sleep at night? _____

Do you view activity or exercise only as a way to burn calories?_____

Do you feel guilty if you miss a designated activity or exercise day?_____

Social History

Level of education _____

Marital/Family Status _____

Current number of people living with you _____

Stress Level on a scale of 1(no stress) – 5 (very stressed) _____

Other

List any other information that you would like to share and feel would be beneficial in determining your individual nutrition goals _____

_____

Please Circle: I give permission for the Berman Group for Wellness and Nutrition to leave a detailed message on my:

- Cell phone
- Home phone
- Both
- Neither

FOOD DIARY

INSTRUCTIONS:
RECORD EVERYTHING YOU EAT AND DRINK FOR 3 DAYS. IT SHOULD REFLECT YOUR USUAL EATING PATTERN, SO YOU MAY WANT TO INCLUDE A WEEK DAY AND WEEKEND DAY IF THEY ARE DIFFERENT.

- Be as specific as possible with type and amount of each food/beverage
- Use common household measurements (cups, ounces, tablespoons, etc.)
- Remember to include meals, snacks and condiments (i.e., 6 oz coffee with 1 oz cream and 2 tsp sugar; sandwich with mayonnaise; salad with regular Italian dressing, etc.)

Day of the Week: _____

Time of Day	Description of Food or Beverage	Serving Size/Amount	Place (home, away, while doing something else, etc.)

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