Nutrition and Eating Habits Questionnaire

Name ___________________________ Date __________________________

Phone __________________________ Email ____________________________

Physician: ________________________________

Date of Birth: _______ Height: _______ Weight: _______ (can leave blank)

Employee: _______ Dependent BSBS eligible: _____ Student: _______

Would you like to have a SECA body composition test: Yes_____ No_____ (There is no additional charge for this test)

Is it okay to have a pet therapy dog in session? Yes_____ No_____

What is the first thing that comes to mind when you think about your eating habits?

Do you like to cook? ______________

Who prepares meals in your home? _____________________

How many meals do you eat away from home on weekdays? ____________________

How many breakfasts? ______ Lunches? ______ Evening Meals? _______

How many meals do you eat away from home on weekends? ____________________

How many breakfasts? ______ Lunches? ______ Evening Meals? _______

List restaurants where you often eat:

_________________________________________

_________________________________________

Do you exercise? No_____ Yes_____
If you do exercise, what do you do? How often do you it?

Is there any reason why you cannot or should not exercise?

Has your weight changed in the last year? (Can leave the next 3 questions blank)

No
Yes, I gained _____ pounds
Yes, I lost _____ pounds

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

How long has it been since you were at that (realistic) weight?

Do you currently take any medicines?

No _____ Yes _____

If you do, list them:

________________________________________________________

________________________________________________________

Have you ever tried medicine to lose weight?

No _____ Yes _____

If you have, list the medicines:
What kind of diets have you tried to lose or gain weight?
________________________

Do you currently take vitamins?
No_____ Yes_____ 

If you do, list them with the amounts that you take:

________________________________________________________________________
________________________________________________________________________

Do you use any other dietary supplements? (Supplements include over the counter herbs, fiber, and sports drinks).
No_____ Yes_____ 

If you do, list the supplements with the amounts that you take:

________________________________________________________________________
________________________________________________________________________

Do you use any meal replacement products (drinks, bars, formulas, etc.)?
No_____ Yes_____ 

If you do, list the types and how often you take them:

________________________________________________________________________
________________________________________________________________________
What kind of beverages do you drink on most days? List the amounts that you typically drink in one day.

Coffee _____ Tea _____ Juice _____
Regular soda _____ Diet soda _____ Water _____
Milk: Whole _____ 2% _____ 1% _____ Nonfat (skim) _____
Alcohol (list type and number of drinks)_____________________________
Other (list type and number of drinks)_____________________________

______________________________________________________________

Do you have any food allergies?

Please list any foods you dislike or will not eat:

Are family members supportive to dietary/lifestyle changes?

Are friends supportive to dietary/lifestyle changes?

Is there anything else that you want the dietitian to know?