Nutrition Intake Questionnaire

Please complete this questionnaire 24 hours prior to your appointment with the dietitian. Failure to complete this form prior to your appointment will result in a rescheduled appointment.

Full Name_____ CWID_____

Date of Birth_____ ☐ Student ☐ Employee ☐ Dependent

Phone_____ Email_____

Primary Care Provider _____ Phone_____

Our clinic has a SECA Medical Body Composition machine that quickly and accurately measures your fat mass, fat free mass, muscle composition, and total body water. The test is painless and takes less only a couple of minutes. There is no additional charge for this test.

Would you like to have a SECA body composition analysis? ☐ Yes ☐ No

What is your reason for scheduling this appointment? _____

_____

LIVING SITUATION

☐ On campus dorm/suite/apartment ☐ Off campus house or apartment

☐ Alone ☐ Roommates or Family (How many additional people live with you?_____)

Check all that apply:

☐ Cook meals at home ☐ Eat with campus dining options ☐ Eat out

Who prepares meals in your home? _____

How many times a week do you eat out? _____ List restaurants you eat at often: _____

_____

Are your family members and friends supportive of dietary/lifestyle changes? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No How many hours of sleep do you get each night? _____

PHYSICAL ACTIVITY

List any reasons you cannot or should not exercise (injury, health condition, etc)? _____

_____

Please describe what types of physical activity you do, duration of activity, and how often:_____

_____

_____

DIETARY INTAKE QUESTIONS

List any food allergies or intolerances:_____

_____

List any foods you dislike or will not eat:_____

_____

Which best describes your appetite? ☐ Good ☐ Fair ☐ Poor

Which best describes your current nutritional intake? ☐ Good ☐ Fair ☐ Poor

List any religious or cultural practices that affect your diet? _____

_____

List examples of a typical day's dietary intake and what time you eat:

Breakfast (Time_____)_____

Lunch (Time_____)_____

Dinner (Time_____)_____

Snacks _____

Beverages and amounts consumed each day:

Coffee_____ ☐ Reg ☐ Decaf Tea_____ (What kind?)_____

Juice_____ (What kind?)_____ Water_____

Sports drinks_____ (What kind?)_____

Regular Soda_____ Diet Soda_____ Milk_____ (What kind?) _____

Alcohol _____ (What kind?)_____

If you take any dietary supplements (vitamins/minerals, herbs, fiber) please list them:_____

_____

If you use any meal replacement products (drinks, bars, formulas, etc) please list them:_____

_____

GENERAL HEALTH QUESTIONS

Height: _____ft _____in Weight (optional): _____pounds

What do you think is a realistic weight for you?_____pounds

Has your weight changed in the last 12 months? ☐ No

☐ Yes, I've gained _____ pounds ☐ Yes, I've lost _____pounds

If you answered yes, was this weight gain or loss intentional? Please explain:_____

_____

How long has it been since you've been your ideal weight? _____

Have you ever tried medications to lose weight? ☐ Yes ☐ No

What diets have you tried to lose or gain weight? _____

Do you or any immediate blood relatives (parents, grandparents, or siblings) have any of the following?

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes ☐ Stroke

☐ Thyroid Disease ☐ Heart Disease ☐ Cancer ☐ Obesity

Please list all prescription and over-the-counter medications you currently take: _____

_____

_____

_____

Is there anything else you'd like the dietitian to know? _____

_____

_____

_____