

## HEALTH & DIETARY QUESTIONNAIRE

CLIENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ PHONE # \_\_\_\_\_

REASON(S) FOR VISIT: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_

INSURANCE NAME, NUMBER & GROUP#: \_\_\_\_\_

<b>PRESENT &amp; PAST MEDICAL &amp; SURGICAL</b>	<b>PLEASE LIST TYPE OF PROBLEM(S)</b>	<b>WHEN? FOR HOW LONG?</b>
<b>CARDIOVASCULAR (INCL. blood pressure)</b>		
<b>GASTROINTESTINAL (stomach intestines, liver)</b>		
<b>UROLOGICAL (bladder, kidney, prostate)</b>		
<b>IMMUNOLOGICAL AUTOIMMUNE (thyroid)</b>		
<b>RESPIRATORY (INCL. asthma, bronchitis)</b>		
<b>REPRODUCTIVE ENDOCRINE/HORMONE (INCL. hysterectomy/why?)</b>		
<b>MUSCULAR-SKELETAL (INCL. arthritis, bone loss)</b>		
<b>NEUROLOGICAL (MS, Parkinson, tremors)</b>		
<b>PSYCHOLOGICAL (PTSD, mental, emotional)</b>		
<b>DERMATOLOGICAL (skin &amp; hair &amp; nails)</b>		
<b>EAR, NOSE &amp; THROAT</b>		
<b>OTHER(S) NOT LISTED</b>		





## EATING BEHAVIOR

1. Do you usually eat breakfast, lunch and dinner, and at what times of the day?

Rationale for skipping meals \_\_\_\_\_  
Do you snack between meals, \_\_\_\_\_, if yes, why? hungry, \_\_\_\_\_ symptoms of low  
blood sugar \_\_\_\_\_ other reason(s), please list \_\_\_\_\_  
What types of snacks do you choose? \_\_\_\_\_

2. Have you ever followed a certain type of diet? \_\_\_\_\_ Diet Type \_\_\_\_\_  
Rationale for the diet \_\_\_\_\_  
Do you avoid certain foods, which ones & why?

3. Do you ever eat when not hungry? \_\_\_\_\_  
Rationale for eating:  
Stressed \_\_\_\_\_ Angry \_\_\_\_\_ Depressed \_\_\_\_\_ Bored \_\_\_\_\_  
Happy \_\_\_\_\_ Social \_\_\_\_\_ Lonely \_\_\_\_\_ Other \_\_\_\_\_

4. Do you ever overeat? \_\_\_\_\_ How often? \_\_\_\_\_ Why & When?

5. Do you ever feel guilty when eating healthy foods \_\_\_\_\_  
or when eating less healthy foods? \_\_\_\_\_

6. Do you feel you are addicted to certain foods, which ones? \_\_\_\_\_

Based on what you learned about nutrition, how do you judge your current dietary choices ?

8. How long does it takes you to eat breakfast? \_\_\_\_\_ lunch? \_\_\_\_\_ dinner? \_\_\_\_\_

9. Do you prefer to make small or large dietary changes? \_\_\_\_\_

10. How many meals do you eat out per week? \_\_\_\_\_ Which places & List the entrees/foods you  
order? \_\_\_\_\_

11. Any other things you would like to disclose about your eating behavior, including past or  
present eating disorders \_\_\_\_\_











## MISCELLANEOUS DIETARY QUESTIONS

How many table spoons of sugar, syrups (LIST TYPE), honey, jams, jellies or spreadable fruit do you use per day, week, or month? Please list types of sweeteners or types of sugar substitutes you use:

What type of cooking oil do you use, how much, how often, is it cold pressed? List **BRAND** of salad dressing(s) and name of salad dressing(s) you use:

What **BRAND/TYPE** of margarine do you use, hard or soft type, or butter, mayo? Organic? On what do you use it? How much? How often?

How often and how much per week do you eat fried foods: ie. Onion rings, french fries, potato/corn chips?

Do you have any known food allergies? If not, do you suspect any food allergies? Which foods are they? Were you ever tested for food allergies? Any other allergies?

## PHYSICAL ACTIVITY

How many times a week do you do aerobic exercise ? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

How long do you exercise? \_\_\_\_\_

How many times a week do you do weight bearing exercise? \_\_\_\_\_

What type of exercise? \_\_\_\_\_

How long do you exercise? \_\_\_\_\_

Do you have any physical limitations that limit your exercise ability? \_\_\_\_\_

Is your current weight a concern? \_\_\_\_\_

What is your height? \_\_\_\_\_ What is your weight? \_\_\_\_\_

What is your weight history? \_\_\_\_\_

## SMOKING/CHEWING HABITS

Did you smoke/chew? If yes, for how long? \_\_\_\_\_

Do you smoke/chew? \_\_\_\_\_

How many cigarettes/dips do you smoke/chew a day/ a week? \_\_\_\_\_

Do you want to quit ? \_\_\_\_\_

Did you ever try to quit? \_\_\_\_\_

What strategies did you use? \_\_\_\_\_

If applicable Why do you think you did or did not succeed? \_\_\_\_\_

Do you eat breakfast?  Never  Occasionally  Frequently  Regularly  always  
Please write down three example meals of what you usually eat for breakfast, include all fluids.

**TIME:**            **FOOD OR BEVERAGE:**    **AMOUNT:**            **FOOD PREPARATION:**

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Do you eat lunch?  Never  Occasionally  Frequently  Regularly  always  
Please write down three example meals of what you usually eat for lunch, include all fluids.

**TIME:**            **FOOD OR BEVERAGE:**    **AMOUNT:**            **FOOD PREPARATION:**

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Do you eat dinner?  Never  Occasionally  Frequently  Regularly  always  
Please write down three example meals of what you usually eat for dinner, include all fluids.

**TIME:**            **FOOD OR BEVERAGE:**    **AMOUNT:**            **FOOD PREPARATION:**

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Do you snack?  Never  Occasionally  Frequently  Regularly  always  
Please write down three example meals of what you usually eat for a snack, include all fluids

**TIME:**            **FOOD OR BEVERAGE:**    **AMOUNT:**            **FOOD PREPARATION:**

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