food history questionnaire & assessment

Name: ___________________________________ Date: ___________________

Occupation: ______________________________

Weight Information

Height: ________ Age: ________ Sex: ________ Current weight: ________

Do you easily maintain your weight? ____

Average weight for the past 2 to 3 years? ____

At what weight do you feel comfortable? ____

When were you last at your comfortable weight? ____

Highest adult weight? ___________ Age: ____________

Lowest adult weight? ___________ Age: ____________

Pre-pregnancy weight? __________ How much weight did you gain with pregnancy? _____________

Were you able to lose all of the weight you gained with pregnancy? ______________________________

Have you lost or gained weight recently? _________ How much? ____________Time frame? _________

Dietary History

Have you ever tried to lose weight before? □ yes □ no

1. Type of Diet: ____

   Short-term results? ____________________ Long-term results? _________________________

2. Type of Diet: ____

   Short-term results? ____________________ Long-term results? _________________________

3. Type of Diet: ____

   Short-term results? ____________________ Long-term results? _________________________

Additional comments you would like to add regarding "dieting" history? ___________________________

____

____

____

____

____

Have you ever used laxatives for weight control? □ yes □ no

Have you ever vomited for weight control? □ yes □ no

Personal Medical History

Please list any medical diagnoses or procedures which have affected your appetite, caused weight gain/loss, or required management with medical nutrition therapy, i.e. diabetes

____

____

____

If you have recent laboratory test results, please list: Date ____________________

Total Cholesterol	______	HDL	______
Triglycerides	______	Glucose	______
LDL	______	Blood Pressure	______

Other ____

Current medications and dosage:

____

____

____

Have you ever been advised by your physician to follow a special diet?

(low salt, low cholesterol, no sugar, etc) □ yes □ no

What changes did you make at that time? ____

____

Have you ever worked with a dietitian/nutritionist? □ yes □ no

If yes, what was your experience? ____

Rate your health: □ excellent □ good □ fair □ poor

Personal Health History

Do you take any vitamin, mineral, or food supplements? □ yes □ no If yes, what type and dose?

_________________________ _________________________ _________________________

_________________________ _________________________ _________________________

Do you have any food allergies? □ yes □ no

If yes, please specify: ____

Do you smoke? □ yes □ no

Do you drink alcohol? □ yes □ no If yes, how many drinks per week? __________________

Family Medical History

Have any immediate family members (parents, siblings, etc) been treated for any of the following:

Diabetes ◻ yes ◻ no

Hypertension ◻ yes ◻ no

High cholesterol ◻ yes ◻ no

Heart disease ◻ yes ◻ no

Stroke ◻ yes ◻ no

Cancer ◻ yes ◻ no

Other (list) ______________________________

____

Eating Patterns

How many meals a day do you eat? ____

Do you skip meals? _______ If yes, which ones do you skip and why? __________________________

____

How often do you snack? ◻ Once daily ◻ Twice daily ◻Three Times daily

When do you usually snack? ____

What foods do you snack on most frequently? ____

____

How many meals per week do you eat at a restaurant? _______________________________________

Which restaurants do you normally choose? ____

How many meals per week do you eat at fast-food restaurants? __________________________________

How does your meal and snack pattern vary on the weekend vs. during the week? _________________

____

What are your favorite foods? ____

____

List any foods you avoid eating: ____

____

Do you have a list of “safe” foods? ◻ yes ◻ no If yes, what are they? __________________________

____

Do you eat standing up? ◻ yes ◻ no

Do you eat in the car? ◻ yes ◻ no

Do you eat at the table? ◻ yes ◻ no

Do you eat with others? ◻ yes ◻ no

Do you engage in other activities when you eat? ◻ yes ◻ no

Do you feel you eat fast? ◻ yes ◻ no

Who usually prepares the food at home? _________________________

Do you cook? ◻ yes ◻ no

Who usually does the grocery shopping? _________________________

Do you read food/nutrition labels? ◻ yes ◻ no

What do you look for on labels? ____

Do you travel and/or entertain for business? □ yes □ no
How often? ____

Eating and Emotion

Do you, or have you ever, used food for comfort or to address other emotions? □ yes □ no
If yes, please elaborate: ____
____
____
____

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes? ____

Do you have a strong support system? ____

Exercise and Activity

Have you ever followed a consistent exercise program? □ yes □ no
Do you currently follow a consistent exercise program? □ yes □ no
If yes, please describe: ____
____

Do you like to exercise? □ yes □ no
What physical activity do you dislike? ____
Do you feel that your life/schedule often conflicts with a healthy exercise program? □ yes □ no
If yes, how? ____
____

When you feel overwhelmed or life gets busy, do you neglect your exercise routine? □ yes □ no
Do you have fitness goals (i.e. run a 5K, etc) you've previously considered, but felt unprepared to work toward? □ yes □ no If yes, please describe: ____
____

Have you ever worked with a personal trainer before? □ yes □ no
If yes, what was your experience like? ____
____

THANK YOU!!

Please bring with you to your first appointment. We look forward to meeting you.