



Nutrition History Questionnaire

Please answer each of the questions below. The information you share will help the registered dietitian have a better understanding of your needs.

Personal Data

Name:

Birth Date: ____/____/____

Today's Date: ____/____/____

Date of most recent fitness assessment: ____/____/____

Trainer's Name:

Height: Current Weight: Current % body fat: Desired Weight and/or % body fat:

Weight at high school graduation:

Lowest weight maintained for a year or more:

What was your age at that time:

Highest adult weight:

Are You concerned about your weight?

Dining Out

Average number of home-prepared meals eaten per week:

Average number of restaurant meals eaten per week:

My restaurant meals tend to be (check all that apply): breakfast lunch dinner

Eating Habits

Are you currently on a diet? If so, please describe:

How do you rate the overall nutritional content of your current diet?

excellent very good satisfactory poor unsure

How do you rate your own ability to plan menus day after day that are heart healthy, cancer preventative, and have the correct mix of calories and nutrients to meet your health and fitness goals?

excellent very good satisfactory poor unsure

Eating Habits Continued...

How many times a day do you include vegetables in your meal plan? (excluding French fries)

0-1 times a day 2-3 times a day 4-5 times a day more than 5 times a day

How many times a day do you include fruit in your meal plan?

0-1 times a day 2-3 times a day 4-5 times a day more than 5 times a day

How many times a day do you include whole grain breads and cereals in your meal plan?

0-1 times a day 2-3 times a day 4-5 times a day more than 5 times a day

How many times a day do you include fried foods in your meal plan?

0-1 times a day 2-3 times a day 4-5 times a day more than 5 times a day

How many times a day do you include milk or dairy foods in your meal plan? (e.g., cheese, yogurt)

0-1 times a day 2-3 times a day 4-5 times a day more than 5 times a day

What type of milk do you usually drink?

Whole 2% 1% Skim Rarely drink milk

How often do you include fish in your meal plan?

2 or more meals/week 1 meal/week 1-3 meals/month Rarely eat fish

How often do you eat baked goods or sweets (for example, pies, cakes, cookies, sweet rolls, muffins, doughnuts, dessert bars, candy, ice cream, frozen yogurt, chocolate)?

Once a day or more 5-7 times a week 2-4 times a week once a week or less

What cooking method(s) do you use at home? (circle all that apply)

Deep fry, fry in oil, breading, roasting, stewing, steaming, grilling, broiling, braising, stir-frying, boiling, baking, slow cooking/crock pot, sauté in oil and/or butter, sauté in juice, water, and/or broth, don't know

When cooking with oil, what oil(s) do you typically use? (circle all that apply)

Canola, corn, vegetable, shortening, olive, margarine, butter, safflower, soy, peanut, don't know, don't cook with oil, other (please list) _____

Average number meals eaten each day:

If less than three, which meal(s) tend to get skipped:

Average number of between meal snacks:

Average number of alcoholic beverage servings consumed per: _____ day or _____ week or _____ month

(Note: 1 serving = 4 oz. (1/2 cup) wine, 12 oz. (1-1/2 cup) regular or light beer, 1-1/2 oz. (1 jigger) distilled liquor 80-100 proof)

Average number of caffeinated beverages consumed per: _____ day or _____ week or _____ month

(Note: 1 serving = 8 oz. (1 cup) of regular or diet soda, coffee, tea, or iced tea)

Average number of 8 oz glasses of water consumed per day:

Eating Habits Continued...

What time do you usually eat your first meal or snack of the day?

What time do you usually eat your last meal or snack of the day?

Are weekend eating habits different from weekday eating habits? If yes, how so?

List all foods that you dislike or rarely eat:

Vegetarians Only

Are you a lacto-ovo vegetarian (that is, you eat milk, cheese, and eggs)? Yes No

Are you a vegan or total vegetarian (that is, you eat only foods of plant origin)? Yes No

Women Only

Have you had a hysterectomy or gone through menopause (i.e., have not had a period for 1 year or more)?

Yes No Currently under transition

Are you currently trying or will you soon be trying to get pregnant?

Are you currently pregnant? If so, what trimester are you in?

Are you currently breastfeeding? If so, what is the age of your infant?

Medical Nutrition Information (All clients)

Has your physician prescribed a special diet for you? No Yes

If yes, please specify _____

Are you taking prescription/over-the-counter appetite suppressants or weight loss aids? No Yes

If yes, please specify _____

Are you taking any vitamin, mineral, and/or food supplements? No Yes

If yes, please specify _____

Do you have any food any food allergies or intolerances? No Yes

If yes, please specify _____

Do you have any specific questions about the impact of nutrition on health? [] No [] Yes
 If yes, please specify:

Current Exercise Program

Please be as accurate as possible. The information you provide is used to determine your caloric needs.

Type of Exercise	# Workouts per week	Minutes of training per workout session	Perceived exertion level per workout session (on a scale of 1-10, 10 being highest)
Weight Training			
Aerobic Training			
Activities (golf, tennis, volleyball, ect.) Please write in type:			

Expectations

What are your expectations for your nutrition consultation?

Do you have any specific questions or concerns that you would like to discuss with the registered dietitian?