Nutrition Pre-Appointment Questionnaire

Name: _____ DOB: _____ Sex: M / F

How did you hear about our services? ☐MD Referral ☐Zoc Doc ☐MCH Display ☐ Other: _____

Have you ever seen a dietitian in the past? ☐Yes ☐No If so, when? _____

What is your primary reason for meeting with a dietitian? _____

What are your long-term health goals? _____

Eating Attitudes

Do any of these apply to you? (*Please check all that apply*)

☐ Eating large portions	☐ Skipping meals often	☐ Use a sugar substitute
☐ Eating too much sugar	☐ No exercise	☐ Consume juice, sweet tea, or soda
☐ Eating too many fatty foods	☐ Don't drink enough water	☐ Drink diet beverages
☐ Consume too much salt	☐ Eat when not really hungry	☐ Consume caffeinated drinks
☐ Eat too fast/not mindfully	☐ Eat lots of fast food	☐ Use frozen meals
☐ Eat a lot of junk food	☐ Eat little/no fruit/vegetables	☐ Food allergies or food aversions

Do you believe you are over or undereating? ☐Yes ☐No

If so, what situations or emotions trigger these habits? _____

Do you have any cravings? ☐Yes ☐No For what? _____

If so, when do you experience these cravings? _____

Do you feel you have a positive body image? ☐Yes ☐No

Please complete the sentence, "For me, an ideal meal would be…" _____

Lifestyle Information

Do you have safe access to exercise? (i.e. walking trail, gym, home equipment) ☐Yes ☐No		
Do you engage in physical activity on a regular basis? ☐Yes ☐No *If Yes, please complete the table below*		
Activity	**Number of Days per Week**	**Duration (minutes) per Session**
Do you have any barriers preventing you from regular exercise? ☐Yes ☐No If so, please explain: _____		

How many hours do you sleep on weekdays? ☐< 6 ☐6-8 ☐8-10 ☐ 10+

How many hours do you sleep on weekends? ☐< 6 ☐6-8 ☐8-10 ☐ 10+

For Diabetic Patients

Do you check your blood sugars at home? ☐Yes ☐No If so, how often? _____

What do your blood sugars normally average? _____

What was your last a1c number and date measured? _____

Nutrition History

Have you ever changed your eating habits for a health reason? ☐Yes ☐No *Please describe.*			
Are you currently following a particular diet or nutrition plan? ☐Yes ☐No *Please describe.*			
Do you avoid any particular foods? ☐Yes ☐No *Please explain.* Do you have any adverse food reactions (intolerances or allergies)? ☐Yes ☐No *Please explain.*			
Height:	**Weight:**	**Usual weight range:**	**Desired Weight:**
Have you recently lost or gained weight? ☐Yes ☐No *If yes, please describe.*			
Do you have or have you had an eating disorder? ☐Yes ☐No *If yes, please describe.*			
How many meals do you eat each day? How many snacks?			
Who primarily does the shopping/cooking in your household?			
Do you ever read the food labels? ☐Yes ☐No If yes, what do you look for?			
How many meals do you eat outside the home **per week**? ☐0-1 ☐2-3 ☐4-6 ☐>6 If consumed outside the home, where do your meals come from? (*check all that apply*) ☐restaurant ☐ fast food ☐ take out ☐ ready-made meals ☐meal delivery service ☐other _____			
Do you drink alcohol? ☐Yes ☐No If so, how many drinks **per week**?			
Do you smoke? ☐Yes ☐No			
Do you drink caffeinated beverages? ☐Yes ☐No If so, how many cups **per day**?			
Do you use any artificial sweeteners? ☐Yes ☐No If so, which ones?			
What is your favorite meal?			

Are you currently taking any vitamins or minerals? ☐Yes ☐No *If yes, please list them below.*

_____

_____

_____

Initials _____

For office use only

Reviewed by: _____ Date _____

Food Diary: Please record what you eat and drink during one typical day (24-hour period). Include all beverages, cream and sweeteners, condiments etc.

Time woke up:		Bedtime:	
Time	**Food/Beverage Item**	**Amount (i.e. cups, tsp.)**	**Location (home/away)**

Name_____ **Signature**_____ **Date**_____

For office use only
Reviewed by: _____ Date_____