Nutrition Visit Questionnaire

Name: _____ Birthdate: _____

1. Health History: Please circle if you have been diagnosed with any of the following:

Arthritis	Heart Attack/Heart Surgery/Stroke
Autoimmune Disease	High Blood Pressure
Anxiety/Depression	High Cholesterol
Cancer (type_____)	Inflammatory Bowel Disease (IBD): Crohn's, Ulcerative Colitis
COPD	Irritable Bowel Syndrome (IBS)
Currently Pregnant/Breastfeeding	Kidney Disease/Kidney Stones
Diabetes	Liver Disease/Fatty Liver
Eating Disorder	Sleep Apnea
GERD (acid reflux)	Weight Loss Surgery

Any other health conditions:
Any surgeries you have had:

2. Please list all prescription medications, over the counter medications, vitamins, and supplements you are taking:

3. What has been your usual bodyweight through adulthood? _____

4. What do you feel is a healthy weight for you? _____

5. Any recent changes in your weight that you are concerned about?
   _____

6. Are you physically active at this time? Yes No Sometimes

7. Do you have anything that limits you from being physically active at this time?
   _____

8. What meals do you eat at home, and what meals do you typically consume at work if applicable? _____

9. Who is in your household, who grocery shops, and who prepares meals?
   _____
   _____

10. Are you currently following any type of diet?
    _____

11. What is your usual eating pattern? Examples: eat 3 meals daily, skip meals, snack throughout the day, no pattern, etc.
    _____

12. How often do you purchase a meal outside the home (restaurant, fast food, work cafeteria, etc.)?
    _____

13. What restaurants do you typically choose?
    _____
    _____

14. What are your barriers to cooking meals at home and bringing meals to work/school?
    _____
    _____

15. Do you have any food allergies or intolerances?
    _____
    _____

16. How often do you consume the following:

Water:	*Daily*	*Weekly*	*Monthly*
Juice:	*Daily*	*Weekly*	*Monthly*
Soda:	*Daily*	*Weekly*	*Monthly*
Tea:	*Daily*	*Weekly*	*Monthly*
Coffee:	*Daily*	*Weekly*	*Monthly*
Alcohol:	*Daily*	*Weekly*	*Monthly*

17. Have you tried diets in the past? If so, which ones:

_____

_____

18. Have you ever worked with a registered dietitian before? If so, what was beneficial and what was not beneficial?

_____

_____

19. If you have diabetes, do you monitor your blood sugar at home? _____If so, what are your typical blood sugar readings? _____

20. I am visiting the dietitian because:

_____

_____

_____

Food Journal

Please record 2 days of food intake. Please indicate the time you wake up, bedtime, time of food intake, as well as portions, how hungry you are before eating and how full you feel after eating, and location of where you ate (kitchen table, desk at office, etc.).

DAY 1

What time did you wake up:

What food items/meal/snacks did you eat? Please include amounts	What time?	Hungry before?	Full after?	Where did you eat?

What time did you go to bed:

DAY 2

What time did you wake up:

What food items/meal/snacks did you eat? Please include amounts	What time?	Hungry before?	Full after?	Where did you eat?

What time did you go to bed: