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Nutrition and Health Information Questionnaire

- ❖ Please fill out this form to the best of your ability. The more detail you provide, the more we can tailor our time together to meet your individual nutrition needs and goals.

Name: ____ Surname______________________________

Age: __________ Height: __________ Weight: __________ Gender: __________

Telephone:

Email:

Marital status:

Primary Reason for Visit a registered Nutritionist:

____

When did your weight problem begin?

_____childhood _____adolescent _____teenager _____

10 years ago _____20 years ago ____30 years ago _____

throughout life other ____

What do you think is reason for your weight gain?

_____injury _____pregnancy _____overeating _____poor eating habits _____heredity _____lack of exercise _____marriage _____smoking cessation _____stress _____divorce other_______________________________

FOR WOMEN:

During your Pregnancy _____any gain weight? IF YES , how many kg?

What is the normal length of menstrual cycle?

Your menstrual cycle should be between **25-35 days** long.

Medical/Health History Please list any past or current medical conditions that you have or are currently being treated for: _______________________________

Total Cholesterol ___

_______ LDL __________ HDL __________ Triglycerides__________

Blood Pressure__________
Other:____

How do you rate your health? _____ Poor _____ Fair __yes both___ Good _____ Excellent

Please circle all that you currently have or have concerns about:

High blood pressure Heart disease Blood clots or clotting disorders

Ankle or feet swelling Nausea/Vomiting Ulcer disease

Diarrhoea Abdominal/stomach pain Rectal bleeding/blood in stools

Heartburn/acid reflux Haemorrhoids Gallbladder disease/gallstones

Celiac disease Belching/burping Constipation

Difficulty urinating Inability to empty bladder fully Urinary incontinence (leaking urine)

Type 1 Diabetes Thyroid disease Abnormal/Absent menstrual periods

Type 2 Diabetes High triglycerides High cholesterol

Gout Bruises easily Skin sores or infections (boils, ulcers, etc)

Low energy level Depression Obsessive-compulsive disorder (OCD)

Bipolar disorder Anxiety disorder/panic attacks Psychological/psychiatric care

Binge eating Anorexia Bulimia

Anaemia Headaches or migraines Cancer (list type): _____________

Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)

Other serious medical conditions:
____

List any medications you are currently taking:
____
____

Do you have a family history of any of the following (circle all that apply)

(parents, grandparents, brothers, sisters)

1. **Obesity**
2. **Diabetes**
3. **Heart Disease**
4. **High Blood Pressure**
5. **Cancer & Type**
6. **Arthritis**
7. **Early Death & Cause**

High blood pressure, high blood cholesterol, diabetes (type 1 or type 2), thyroid disease, obesity, heart disease, cancer, other (list):
____

List the types of surgeries you have had:

____

____
____

Do you have any food allergies or medically diagnosed intolerances? Y / N (Circle one) If yes, please list: ________________ ____

Do you take any vitamin/mineral/herbal/sports supplements? Y / N (Circle one) If yes, please list: ____________________

Do you smoke? Y / N (Circle one) If yes, how often/how much:

____

Do you drink alcohol? Y / N (IF YES)

How often do you consume alcohol?

○ Daily ○ Weekly ○ Monthly ○ Occasionally ◉ Never

How many hours of sleep do you average per night? _______

Is your sleep restful? Yes No

How many times a day do you defecate?

Please rate your daily stress level:

1 Low Stress **10** High Stress

1 2 3 4 5 6 7 8 9

Food & Nutrition History

Please list any religious practices that affect your health care or diet:

____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

If you are not ready to make lifestyle changes, what are the barriers preventing you from being ready?

Are your meals?

_____large portion medium portion _____extra large portions

_____high fat _____high carbohydrate _____high sugar

How often do you snack? _____ a.m. snack _____p.m. snack _____evening snack _____snack between all meals _____grazing on food throughout the day

How many times a day do you typically eat: ______

From the list below what triggers you to eat:

_____availability of food _____depression _____loneliness _____boredom _____habit
_____hunger _____lack of appetite awareness _____self reward _____external cues
_____comfort _____stress _____social situations _____anxiety _____sadness other
______________________________ _____anger

How would you describe your eating habits?

- Skip one meal per day
- feeling disgusted or guilty after
- Reported often eating (i.e. grazing) overeating
- Rapid eating
- eating large amounts of food
- Eating until uncomfortably full
- throughout the day
- Eating alone out or embarrassment
- Middle of the night eating

Do you consume caffeinated beverages on a regular basis? (Check all that apply) ____

Coffee ____ Tea ____ Soda ____ Energy Drinks

Do you avoid any of the following foods?

(Check all that apply) ____

Red meat ____

Fruits

Sweets (candy, desserts)

Poultry (chicken, turkey) ____

Fried food ____

Alcohol ____

Fish ____

Breads ____

Fats/oils (mayo, dressing, butter) ____

Dairy (milk, cheese) ____

Grains (pasta, rice) ____

Vegetables ____

Fast food

Foods you especially like: ____________

____

Foods you especially dislike: _________________

____

Weight History

Has your appetite changed recently? Y / N (Circle one)

If yes, please describe: ____________

____

____

Have you recently gained or lost weight? If yes, please explain whether it was a gain or loss and what changes led to the change in weight.

____

Have you ever had concerns about your weight? Y / N (Circle one)

___ Underweight ___ Overweight

Comment:

____

Have you ever tried to lose or gain weight in the past? Y / N (Circle one) If yes, please describe:

Overall, how satisfied are you with the physical appearance of your body? (Check one)

____ Very satisfied ____ Somewhat dissatisfied ____ Somewhat satisfied ____ Very dissatisfied

Physical Activity History

Do you know of any reason(s) why you should not do physical activity? If yes, please explain reasons.

____

Are you currently physically active? Y / N (Circle one)

If yes,

How often: ___________ times per week How long: ____________ minutes per session

Please rate the average intensity of your workouts:

(Circle one)

- Light (walking slowly, sitting, standing)
- Moderate (walking briskly, heavy cleaning, light bicycling)
- Vigorous (hiking, running, fast bicycling, most team sports, weight lifting

Nutrition Goals What nutrition-related goals do you have? What eating habits would you like to work on? ______________

How important is it to you to make changes in your nutrition habits? (Please circle)

1 Unimportant **10** Very Important

1 2 3 4 5 6 7 8 9 10

How confident are you in your ability to improve your nutrition habits? (Please circle)

1 Unimportant **10** Very Important

1 2 3 4 5 6 7 8 9 10