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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.

1. Weigh yourself at the same time every day (morning is best, after using the restroom).
2. Use a quality weighing device that's set up properly.
3. Only use one scale.
4. Weigh yourself naked or wear the same thing for every weight measurement.

Name: _____Surname_____

Age: ____ Height: _____ Weight: ____ Gender: ___ Occupation:

Telephone:

Email:

Marital status:

Children & ages:

Please list the people in your household and their relationship to you:

Referred By:

□ Self □ Health Clinic □ Counseling & Psychological Services (CPS) □

Other: _____

Have you ever seen a registered nutritionist before? □ Yes □ No If yes, who and when?

Date of most recent blood tests:

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/pounds?

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 If yes, please list: _____

Do you take any vitamin/mineral/herbal/sports supplements? Y / N If yes, please list: _____

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

Tobacco Use:

- I currently smoke
- I quit smoking less than six months ago
- I quit smoking over six months ago
- I never used tobacco

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

Alcohol Use:

- I frequently drink alcohol
- I occasionally drink alcohol
- I seldom drink alcohol
- I never drink alcohol

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 anger

other:

What make sit difficult to follow your diet?

☐ Eating at home

☐ Eating away from home

☐ Eating around other people who don't have to worry about their diet

☐ Preparing my own food

☐ Remembering to take my food with me

LIST the food that are the most difficult for you to avoid or limit:

1.

2.

3.

4.

5.

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?

Red meat

Fruits

Sweets (candy, desserts)

Poultry (chicken, turkey)

Fried food ____

Alcohol ____

Fish ____

Breads ____

Fats/oils (mayo, dressing, butter) ____

Dairy (milk, cheese, yogurt) ____

Grains (pasta, rice) ____

Vegetables ____

Fast food ____

Nuts (almonds, walnuts, seeds) ____

Tahini, peanutbutter, avocado ____

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