

Nutritional Assessment: Questionnaire

Date: _____/_____/_____

Name: _____

Telephone: _____ email address: _____

Occupation: _____

Marital status: _____

Age: _____ Gender: Male _____/ Female _____ Height: _____

Have you experienced any changes in your weight in the last 6 months?

- Weight loss of _____ lbs
- Weight gain of _____ lbs
- No change in weight _____
- If weight loss, was it planned _____

Are you pregnant? _____ yes _____ no; if yes, due date: _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Have you had recent changes in appetite?: _____

Lifestyle

How many times do you exercise per week (once, 2-4 times, 5 times, more) _____

Types of physical activity or exercise you do: _____

Symptoms

Do you experience:

- Heartburn or acid reflux _____
- Bloating shortly after eating _____
- Lump in throat _____

Are you a vegetarian (no dairy, meat, fish or eggs) _____

Do you feel like skipping breakfast _____

Do you crave bread or noodles _____

Do you crave chocolate _____

Do you crave fatty or grease foods _____

Have you been or are on low or reduced fat diet (past or present) _____

Do you crave salty foods _____

Do you crave sweets _____

Do you binge or experience uncontrolled eating _____

Do you have excessive appetite _____

Do you crave coffee or sugar in the afternoon _____

Are you irritable before meals _____

Are you shaky if meals are delayed _____

Do you experience frequent thirst _____

Frequent urination _____

Do you have difficulty gaining weight, even with large appetite _____

Do you have difficulty losing weight _____

Do you feel sleepy after meals _____

Do you have chronic diarrhea _____

Do you have diarrhea shortly after meals _____

Do you have alternating constipation and diarrhea _____

Is your stool hard or difficult to pass _____

Are stools not well formed _____

Do you have blood in your stool _____

Are you having any problems with? If yes please circle your problem.

1. Chewing
2. Swallowing
3. Nausea
4. Vomiting
5. Diarrhea
6. Constipation

Do you experience pains in your stomach for which you use antacids occasionally _____

Medical history

Did you have your gallbladder removed_____

Are you a recovering alcoholic_____

Do you have a history of drug or alcohol abuse_____

Do you have a history of hepatitis_____

Have you used certain medications on a long-term basis, if yes please specify

Do you have pain under right side of rib cage_____

Do you have food allergies_____

Do you have Crohn's disease_____

Do you have Celiac disease_____

Do you have high blood pressure (normal 120/80)_____

Are you lactose intolerant_____

Do you have asthma, sinus infections_____

Do you have a tendency to anemia_____

Do you have family members with diabetes_____

Do you suffer from depression_____

Do you experience pounding heart_____

Do you have history of kidney stones_____

Do you have any of the following conditions?

- Allergies_____
- Anxiety_____
- Arthritis_____
- Asthma_____
- Cancer type_____ date of diagnosis_____
- Depression_____
- Diabetes or family history_____
- Faint spells, weakness_____
- Heart disease (heart attack, peripheral artery disease or family history, high cholesterol)_____
- Have you ever had a heart attack or stroke_____
- Do you have high triglycerides_____
- High blood pressure or family history_____
- Irritable bowel syndrome_____
- Low blood sugar_____
- Physical disability_____
- Surgery recently_____
- Do you have osteoporosis_____
- Are you menopausal or postmenopausal_____
- Do you have stomach or duodenal ulcers_____
- Do you have a hiatal hernia or do you experience a burning sensation in the throat or chest when you lie down_____
- Have you ever had high blood pressure_____

- Do you have respiratory allergies or asthma_____

Behavioral aspects of nutrition

Do you think you eat a lot more than other people do_____

Do you feel you cannot stop eating once you have started. _____

Do you feel you loose control of what and how much you eat._____

Do you eat until you feel very full_____

Do you eat when you are not hungry_____

When you are anxious, depressed, bored do you feel relief in eating_____

Do you happen to hide the food you are eating because you feel guilty of the amount you are eating_____

If you happen to binge eat you feel guilty or depressed_____

Have you been bingeing for more than 6 months_____

Do you happen to be bingeing more than twice a week_____

Does this depress you, does it make you feel guilty_____

Completed by:_____ date :_____