

Nutrition Questionnaire

Name: _____ **Email Address:** _____

Date: _____ **Address:** _____

Phone Number: _____ **Preferred Method of Contact:** _____

1. Present Weight: _____ Usual Weight: _____ Desired Weight: _____

Height: _____ Age: _____ Birth date: _____

2. Occupation: _____ Hours worked per week: _____

3. On a scale of 1 through 10 (1 being lowest and 10 being highest) rate your level of stress: ____

4. For Women:

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

Frequency of menstruation: _____ or age at menopause: _____

5. For Men:

Do you have a family history of prostate cancer? _____

6. Have you had any recent changes in appetite or eating patterns (explain)?

7. Have you had any recent changes in weight (explain)?

8. Do you have any problems with...

Explain

Sleeping _____ yes _____ no _____

Headaches _____ yes _____ no _____

Nausea _____ yes _____ no _____

Vomiting _____ yes _____ no _____

Diarrhea _____ yes _____ no _____

Constipation _____ yes _____ no _____

Food Shopping _____ yes _____ no _____

Food Preparation _____ yes _____ no _____

9. Please list any foods you prefer to avoid: _____

10. Do you drink alcohol or use tobacco products? _____ yes _____ no

If yes, how often? Alcohol: _____ Tobacco: _____

11. Do you use recreational drugs? If yes, please list: _____

12. Please list all medications and nutritional supplements you are taking and reason for taking:

Drug/Supplement:	Reason:

Please continue on another sheet of paper if more room is required.

13. Personal Medical History (check those the conditions you have or have had in the past):

High Cholesterol	<input type="checkbox"/>	Asthma	<input type="checkbox"/>
High Triglycerides	<input type="checkbox"/>	Alcohol or Drug Abuse	<input type="checkbox"/>
Heart Attack/Stroke	<input type="checkbox"/>	Eating Disorder	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Depression	<input type="checkbox"/>
Irritable Bowel Syndrome	<input type="checkbox"/>	Food Allergies/Sensitivities	<input type="checkbox"/>

14. Have you ever seen a dietitian or medical professional regarding nutrition-related problems?

_____ yes _____ no If yes, explain _____

15. What would you like to achieve with a series of nutritional counseling sessions? _____

16. Who is your physician? _____

Please read and sign the following statement:

“I have provided accurate medical information to my best ability. I understand that in order for Wendy Peterson, RD to provide the best nutritional care for me that she may need to contact my physician for further information.”

Client Signature