**Nutrition Questionnaire**

To give you personalized care and attention, the dietitian needs to know a little bit about you and your lifestyle. Please take a few minutes to answer the following questions. Try to answer them as completely and honestly as possible.

Please complete the questionnaire and call to schedule an appointment with the nutrition consultant. Please contact:

Anne Blocker, MS, RD/LD, CDE  
Registered Dietitian and Nutrition Consultant  
blocan02@luther.edu  
Luther College  
700 College Drive  
Decorah, Iowa  52101-1045  
Phone: 563-387-1059

Name  

Gender  
Age  
Date  

Phone  
Email  

Address  

**General Information**

What do you hope to accomplish from this appointment?  

Do you currently take any vitamins or supplements?  Yes ☐  No ☐  
If yes, please list:  

Do you currently take any medications?  Yes ☐  No ☐  
If yes, please list:  

Height: _____ ft. _____ in.  Weight: _____ lbs.  

What would you like to weigh? _____ lbs.  

Do you smoke?  Yes ☐  No ☐  If yes, how much?  

What is your family’s health history: (Check all that apply.)

☐ Heart disease
☐ Diabetes
☐ Cancer
☐ High blood pressure
☐ High cholesterol
☐ Other

What is your health history? __________________________________________________________

What questions do you have for the dietitian? __________________________________________

Physical Activity

Do you currently exercise? Yes ☐ No ☐

How frequently do you exercise aerobically? _______ days/week _______ how long? _______ minutes/day

What do you do for aerobic activity? ___________________________________________________

How frequently do you strength train? _______ days/week _______ How long? _______ minutes/day

What do you do for leisure activities? __________________________________________________

Do you have any exercise limitations? Yes ☐ No ☐ If yes, please describe: _____________________________

Dietary Habits

How would you rate your diet? Excellent ☐ Good ☐ Fair ☐ Poor ☐

Has your appetite changed within the past month? Yes ☐ No ☐

If yes, please explain: _____________________________________________________________________
Do you have any food allergies or food intolerances?  Yes ☐  No ☐

If yes, please list: ________________________________________________________________

Have you ever been on a diet?  Yes ☐  No ☐

If yes, what diets have you tried? __________________________________________________

Are you currently following a special diet (ex. low fat, low salt)?  Yes ☐  No ☐

If yes, what diet are you on? ______________________________________________________

Have you ever purposefully restricted food intake and obtained what you or others felt was an extremely low or unhealthy weight?  Yes ☐  No ☐

If yes, please explain: _____________________________________________________________

Have you ever thrown up, used laxatives, fasted, or exercised for long periods of time to lose weight?

If yes, please explain: _____________________________________________________________

Who prepares your meals? _________________________________________________________

Where do you eat your meals? _____________________________________________________

With whom do you eat your meals? __________________________________________________

What is a normal meal pattern for you? (Check all that apply) ☐ Breakfast  ☐ Mid-morning snack
☐ Lunch  ☐ Mid-afternoon snack  ☐ Dinner  ☐ Evening snack

Indicate the usual time you eat: _______ Breakfast _______ Lunch _______ Dinner _______ Snacks

Please list the foods you typically have for:

Breakfast: _____________________________________________________________________

Lunch: _______________________________________________________________________

Dinner: ______________________________________________________________________

Snacks: ______________________________________________________________________

How often do you eat fast food or go to a restaurant?  ☐ 0-1 times/month  ☐ 2-3 times/month
☐ 1-2 times/week  ☐ 3-4 times/week  ☐ 5+ times/week

List the restaurants you eat at when dining out: ______________________________________
______________________________________________________________________________
Which of the following beverages do you drink regularly? (Check all that apply.)

☐ Milk
☐ Juice
☐ Soda/pop
☐ Coffee/tea
☐ Water
☐ Sports drinks
☐ Other

How often do you drink alcohol?  ☐ 0-1 times/month  ☐ 2-3 times/month  ☐ 1-2 times/week  ☐ 3-4 times/week  ☐ 5+ times/week

When you do drink, on average, how many servings of alcohol do you drink in one sitting (1 serving = 12 oz. beer, 5 oz. wine, or 1 oz. liquor)? _______ serving(s)