**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)