HANSEN
HEALTH SOLUTIONS

Nutrition Questionnaire

Patient Name _____ Birthdate ____/____/____ M / F

The food/nutrition questions that I would like to ask are:

_____

_____

_____

_____

_____

_____

_____

Tell me about your eating situation.
◇ I am single and eat foods that I prepare (most of the time) from home
◇ I am single and busy, so I eat out a lot
◇ I am married and my spouse and I do our best to make homemade meals happen
◇ I am married and we are both busy, so we typically eat out a lot
◇ I have a small family (spouse/no spouse, 1-2 children)
◇ I have a larger family (spouse/no spouse, 3+ children)

Tell me about your skill level in the kitchen.
◇ I love to cook/prepare food
◇ I don't like to cook/prepare food
◇ I never learned how and don't have desire/time
◇ I learned but don't have time
◇ I do cook/prepare foods sometimes, but it's infrequent
◇ I don't have time to get groceries, so it doesn't happen

On average, what would you say you currently spend on food weekly/monthly? $_____/week $_____/month

Which meals do you eat regularly, circle all that apply:

Breakfast Lunch Dinner/Supper Snacks

Write down the approximate times that you eat the following meals:

	Time
◇ Breakfast	_____am/pm
◇ Lunch	_____am/pm
◇ Dinner	_____am/pm

◇ 1st Snack _____am/pm ◇ 2nd Snack _____am/pm ◇ 3rd Snack _____am/pm
◇ I eat when I can, I do NOT have a set schedule

When eating out, which restaurants do you prefer?

_____

_____

If you follow a special diet/nutritional program, circle the following that apply:

Low Fat	Low Sodium	Vegan	No Wheat
Low Carb	No Gluten	Diabetic	No Grains
High Protein	Vegetarian	No Dairy	Other _____

Do you feel like you have an emotional relationship with food? ◇YES ◇NO
If yes, explain _____

_____

_____

Have you ever had any type of eating disorder? ◇YES ◇NO
If yes, which disorder? _____
For how long were you challenged by this? _____

On a scale of 1 (not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

To improve your health, how ready/willing are you to…	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Engage in regular exercise/physical activity					

Beverage Intake: Please indicate the beverages you drink, and how often you drink them. Fill in the "Daily Amount", "Weekly Amount", and/or "Monthly Amount".

Beverage Type	Daily Amount	Weekly Amount	Monthly Amount
Example: Coffee: Reg Decaf Latte	2 – 8 oz cups	__	__
Water: Tap Filtered Bottled			
Coffee: Reg. Decaf. Latte			
Tea: what type(s)?_____			
Juice: Natural Fruit drinks			
Soda: Regular Diet			
Milk: whole 2% 1% skim			
Milk alternative Type: _____			
Alcohol: wine beer liquor			
Other _____			

Food Intake: Please indicate the frequency that you eat the following:

How often do you eat:	**Never**	**2-3 times/mo.**	**1 time/wk**	**2-3 times/wk**	**1 time/day**	**2-3 times/day**
Fast food						
Restaurant food						
Vending Machine food						
Cafeteria or buffet food						
Frozen meals						
Home-cooked meals						
Beef (hamburger, steak, etc.)						
Pork (chop, loin, ham, bacon, etc.)						
Liver						
Lamb						

Poultry (chicken, turkey, etc.)						
Deli meat, type:_____						
Fish, type:_____						
Soyfoods, type:_____						
Beans, type:_____						
Nuts, Nut Butters (peanut, almond)						
Chocolate, Candy						
Cookies, cakes, muffins						
Whole grains, type: _____						
Fresh/Raw vegetables						
Cooked vegetables						
Fruit, fresh or frozen						
Canned Vegetables or Fruit						
White Flour, Rice, Bread, Crackers, and other grains						
Canola, Vegetable oil, Shortening						
Margarine						
Dairy (Milk, yogurt, cheese, butter)						
French fries						
Fried meat (steak, chicken, fish)						
Foods with added sweeteners/sugar, type: _____						
Artificial sweeteners, type:_____						
Meal Replacements, (Protein Shakes) type: _____						

Physical Activity: Using the table, please describe your physical activity.

Activity	Type/Intensity (low-moderate-high)	# Days per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting)			
Sports			
Other (specify/describe)			

Please indicate how often you experience the following symptoms:

Symptom:	Often	Sometimes	Rarely
Heartburn			
Gas			
Bloating			
Stomach Pain			
Nausea/Vomiting			
Diarrhea			
Constipation			

How often do you have a bowel movements? _____ /Day or _____/Week

On average, how many hours of sleep do you get? Weekdays_____ Weekends_____

Eating Style: Based on how you eat on a regular basis, please circle all that apply:

Fast Eater	Family member(s) have different tastes	Eat too much
Erratic eater	Love to eat	Late night-eater
Time constraints	Negative relationship with food	Dislike “healthy” food
Travel frequently	Frequently eat fast food	Poor snack choices
Eat because I have to	Struggle with eating issues	Confused about food/nutrition
Rely on convenience items	Do not plan meals/menus	Emotional eater (stressed, bored, sad, etc.)