

Nutrition/GI Health Assessment Questionnaire

1. Describe your current health lifestyle

- a. Great! I follow a healthy lifestyle by _____
- b. Needs work, but ready to make changes to _____
- c. Needs work, but not ready to make changes

2. Describe your current weight (normal, overweight, underweight) and how you feel about it:

3. Describe your current eating habits (grazer, binge eater, sugar/salt craving, balanced diet etc.)

4. What time is your first meal or beverage (besides water or black coffee)? _____

What time is your last meal (snack/beverage)? _____

5. How much water do you drink?

- a. Not sure - Not enough
- b. Not sure - I think I drink enough
- c. I drink ___ oz each day

6. Do you take any supplements (multi-vitamin, protein shakes etc.)?

No

Yes: _____

Food Frequency Questionnaire

How many days a week do you eat/drink:

- _____ Fish
- _____ Processed Sugar (cookies, ice cream, etc.)
- _____ Sugar sweetened beverage (soda, juice etc.)
- _____ Diet drink
- _____ Alcoholic beverage
- _____ Beans/Lentils
- _____ Nuts/Seeds
- _____ Berries
- _____ All other fruit
- _____ Cruciferous Vegetables (broccoli, cauliflower, brussels sprouts)
- _____ Dark Leafy Green Vegetables (spinach, kale, arugula)
- _____ Fast Food
- _____ Processed meat and cheese

How many times a week do you eat out: _____

Foods you love (and cannot live without): _____

Foods you dislike: _____

What obstacles do you face when trying to improve diet? _____

Lifestyle Questions

1. How many hours of sleep on average do you get each night? _____
How do you feel about your sleep quality/quantity? _____
2. What is "exercise" for you? _____
How many days a week do you exercise? _____
How many minutes a day do you spend exercising or moving? _____
3. Rate your stress on a scale of 1 to 10 (10 being the highest) _____
4. Where does stress originate (work, school, family etc.)?

5. Do you struggle with any other psychological issues (anxiety, depression, worry, loss of interest etc.)?
 - a. No
 - b. Not sure
 - c. Yes: _____
6. Have you ever seen a therapist/counselor/psychiatrist?
 - a. No
 - b. Yes: _____ for _____. When: _____
 - c. I am open to see one
7. What do you consider rest? (example: reading, going to the beach, spending time with family)

8. How many times have you been on an antibiotic regimen in your adult life?
 - a. Never
 - b. 1-3
 - c. 4+
9. Have you taken antibiotics in the last year?
 - a. No
 - b. Yes – When? _____
10. Have you done genetic testing (23andMe, Ancestry DNA), nutrient analysis, or Microbiome stool test?
 - a. No
 - b. Yes _____

On a scale of 1-10, how likely are you to make dietary changes? _____

What do you need most out of this visit with the dietitian? _____

Please share any other pertinent information about diet and lifestyle

Thank you for filling out this questionnaire!