Adult & Adolescent Nutrition Questionnaire

1. Name: _____
2. Age: _____ Date of birth: _____
3. Weight:_____ lbs. Date: _____ Height: _____ inches Date: _____
4. Current Medical issues: _____
   _____
   _____
5. Past medical history:_____
   _____
   _____
6. Do you know the values of your last cholesterol?: ____, LDL: ____, HDL: _____, triglycerides: _____ Date_____
7. How is your blood pressure? ___ high, ____low, ____normal.
8. Please tell me about your weight history: stable ___, up and down ____ # lbs
9. Have you ever been on a diet to lose or gain weight? Yes No
   If yes what type of diets have you tried?_____
10. Please List all medications you are currently taking:_____
    _____
    _____
11. Please list all supplements you are currently taking: _____
    _____
    _____
12. Do you exercise? Yes No
    If you exercise what type of exercise do you do and how often do you exercise?
    _____
    _____
13. Do you smoke? Yes No # cigarettes/ day____ /week____.
14. Are you under a lot of stress in your life? yes no
15. Do you tend to eat more or less when you feel stressed? More less
16. What foods do you tend to eat when you feel a lot of stress? _____
    _____
    _____
17. Do you experience problems with constipation? ___yes ___no, if yes, how frequently: _____

Eating Habits:

18. How often you eat out at restaurants? _____
    How often do you eat at other peoples homes?_____
    Do you bring your lunch to school/work or buy it?_____
    How many meals do you eat/day? _____
    How many snacks do you eat/day? _____
    What time of day do you like to eat snacks? _____
    What kind of snacks do you like to eat? _____
    What type of beverages do you like to drink?_____

How many glasses of water do you drink/day?_____
Do you drink coffee/tea? Yes No How many cups/day?_____
Do you drink alcohol? Yes No
If yes how many cups/day____ cups/week____ cups/month_____

19. Please tell me a little about your food shopping habits?
Who does the shopping in your household? _____
Do you or they make a shopping list before you go shopping? yes no
How many time a week do you or someone else shop for food? ___ /week
Where do you do most of your grocery shopping? _____
Do you read labels when you shop? yes no
Is there anything about your grocery shopping habits that you would like my help to change or improve? yes no
If yes what would like help with? _____

22. What goals would like to work on around your nutrition, diet and/ or lifestyle?

23. Please list any questions or concerns you may have here and complete the 24 hour recall on the next page. Thank-you.

Please record below what you typically eat in one day.

Time of day and location of meal or snack?	What did you eat? Include all food and beverages	How much did you eat or drink?	How was it prepared?	Office use