Northwest Natural Health
A Specialty Care Clinic

NEW NUTRITION PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name_____ **Date**_____

Background Questions

Please list the people in your household and their relationship to you: _____

_____

What is the highest level of education you have attended? _____

What prompted you to seek dietitian services at this time? _____

What personal goals can we help you achieve? _____

How ready are you to make lifestyle changes? (choose #) _____ (Not ready 1 2 3 4 5 Very ready)

Overall Health Questions

Date of your last physical exam: _____ Date of last blood testing: _____

How do you rate your health? (check one) □ excellent □ good □ fair □ poor

Height: _____ Current Weight: _____

What was your lowest body weight as an adult? _____ Highest? _____

Preventative care screenings and diagnostic tests you have had (check all that apply):

□ Sigmoidoscopy/Colonoscopy
□ Mammogram
□ Cardiac Stress Test
□ Prostate/Testicular Exam
□ Bone Density

Do you have any allergies or intolerances to medications or foods? _____

Average hours of sleep each night: _____ Is your sleep restful? □ Yes or □ No

How would you rate your stress level? (choose #) _____ (Low 1 2 3 4 5 High)

How do you cope with daily stressors? _____

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NUTRITION QUESTIONNAIRE

What 1 or 2 things would you like to change about your diet? _____

What eating habits are you most proud of? _____

What eating habits need the most improvement? _____

What foods do you dislike? _____

What foods do you crave? _____

What is your usual eating pattern (check all that apply):

□ varies day to day □ varies week vs. weekend □ grazer □ no pattern/random

□ skip meals □ nighttime eating □ 3 meals/day □ 3 meals + snacks

Who performs the cooking/shopping? _____ What grocery store? _____

How would you rate your cooking skills? (choose #) _____ (Inexperienced **1 2 3 4 5** Skilled)

What do you drink with meals and in-between meals? _____

If you snack, what do you usually snack on? _____

How often do you travel? _____

Out of 7 days, how often do you dine out for: Breakfast? _____ Lunch? _____ Dinner? _____

What types of restaurants do you typically frequent? _____

How often do you eat in front of the TV or computer? _____

What triggers you to eat? (check all that apply)

□ time of day □ hunger □ seeing/smelling food □ emotions □ boredom □ other

Do any religious practices or food philosophies affect your diet (ex: Kosher, Vegetarianism)? (describe)

_____

Do you eat more rapidly than others? □ Yes or □ No

Do you eat until feeling uncomfortably full? □ Yes or □ No

Do you eat large amounts of food when you are not feeling physically hungry? □ Yes or □ No

Do you eat alone because of being embarrassed by how much you eat? □ Yes or □ No

Do you feel disgusted, depressed, or guilty after overeating? □ Yes or □ No

Do you feel that you cannot control the amounts you are eating? □ Yes or □ No

Do you have a history of the following? (check all that apply)

□ compulsive over eating □ binge eating disorder □ anorexia □ bulimia □ other

What diets have you tried to lose weight?

_____

How confident are you about the ***amount*** of current nutrition knowledge you have?_____ (Low 1 2 3 4 5 High)
How confident are you about your ability to ***apply*** the nutrition knowledge you have? _____ (Low 1 2 3 4 5 High)

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PHYSICAL ACTIVITY QUESTIONNAIRE

What is the most active thing you do in an average day? _____

What, if any, regular exercise do you participate in? How often? (describe)

_____

What physical activity would you like to do that you are currently not doing? _____

If you answer *yes* to any of the following questions, check with your doctor before starting an exercise program:

Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?	□ Yes or □ No
Do you feel pain in your chest or shortness of breath when you do physical activity?	□ Yes or □ No
In the past month, have you had chest pain when you were not doing physical activity?	□ Yes or □ No
Do you lose your balance because of dizziness or do you ever lose consciousness?	□ Yes or □ No
Do you have a bone/joint problem that may worsen by a change in your physical activity?	□ Yes or □ No
Is your doctor currently prescribing drugs for your blood pressure or heart condition?	□ Yes or □ No
Do you know any other reason why you should not do physical activity?	□ Yes or □ No

Thank you for choosing Northwest Natural Health®.
We appreciate the opportunity to participate in your care.

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