**NUTRITION SERVICES**  
**Assessment Questionnaire**

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**Name (Last, First)**

**Phone Number**

**Race (please check all that apply)**

- American Indian/Alaska Native
- Asian
- Black/African American
- Native Hawaiian
- Other Pacific Islander
- Unreported/
- White
- Refused to Report

**Gender**

- Female
- Male

**Age**

**Who referred you to our services?**

- Advisor/Professor/TA
- Campus Rec
- CAPS
- Coach/Athletic Staff
- Family Member
- Friend
- Health Center Staff
- Self
- Residence Hall Staff
- Other

**Have you seen a dietitian before?**

- Yes
- No

**Why do you want to see a dietitian? (please check all that apply)**

- Anemia
- Diabetes
- Disordered eating concerns
- Food Intolerance
- General healthy eating advice
- High blood pressure
- High cholesterol
- Irritable Bowel Syndrome
- Other

---

**MEDICAL HISTORY**

**Are you currently being treated for a medical condition?**

- Yes
- Not Sure
- No

**Are you taking any medications or over-the-counter drugs?**

- Yes
- Not Sure
- No

**Are you taking any supplements or herbs?**

- Yes
- Not Sure
- No

**Do you have a family history of diabetes?**

- Yes
- Not Sure
- No

**Do you have a family history of high cholesterol?**

- Yes
- Not Sure
- No

**Do you have any food allergies or intolerances?**

- Yes
- Not Sure
- No

---

**QUESTIONS**

**Height**  
____ feet  
____ inches

**Present weight, if you know**

**Usual weight**

**Desired weight range**

**Weight when you graduated from high school**

**Have you had any recent weight change?**

- Gain
- Loss

**How much and how fast:**

**Have you ever had concerns about your weight?**

- Yes
- Overweight
- Underweight
- Comments:

- No

**Who referred you to our services?**

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- Gain
- Loss

**How much and how fast:**

**Have you ever had concerns about your weight?**

- Yes
- Overweight
- Underweight
- Comments:

- No

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**QUESTIONS**

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____ feet  
____ inches

**Present weight, if you know**

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**Have you had any recent weight change?**

- Gain
- Loss

**How much and how fast:**

**Have you ever had concerns about your weight?**

- Yes
- Overweight
- Underweight
- Comments:

- No
### EATING BEHAVIORS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>If yes, explain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does your food intake or your weight feel out of control?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Has your appetite changed within the last month?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>How many meals do you eat per week at:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fast-Food Chain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restaurant</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dining Hall</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Greek house</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you generally describe your eating habits?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Good</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Fair</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Poor</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>How often do you eat fewer than 3 times a day?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Daily</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Weekly</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Rarely</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Almost daily</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>If you skip meals, which meals do you most often skip?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>How many snacks do you eat most days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ No</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Who prescribed or suggested this diet for you?</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Family</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Physician</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Friend</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Self-elected</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Please specify type of diet:</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Diabetic</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Gluten free</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Low carb</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Vegetarian</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>☐ Other (describe)</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

### BEVERAGES

<table>
<thead>
<tr>
<th>Beverage</th>
<th>☐ Reg. soda</th>
<th>☐ Reg. coffee</th>
<th>☐ Tea</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Diet soda</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Decaf. coffee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Protein drink</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ 100% fruit juice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Plain water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Energy drink</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Fruit drink/punch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Flavored water</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Other (please explain)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ALCOHOL

<table>
<thead>
<tr>
<th>How often do you drink alcohol?</th>
<th>☐ 0-1 time/month</th>
<th>☐ 1-2 times/week</th>
<th>☐ 5+ times/week</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ 2-3 times/month</td>
<td>☐ 3-4 times/week</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ Do not drink</td>
<td>☐ 1-2 drinks</td>
<td>☐ 3-5 drinks</td>
<td>☐ 6-8 drinks</td>
</tr>
<tr>
<td>(1 drink = 1.5 oz. liquor, 5 oz. wine, or 12 oz. beer)</td>
<td>☐ 9 or more drinks</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### TOBACCO

| Do you smoke? | ☐ Yes | If yes, how much? | ☐ No |
|               |       |                   |      |

### PHYSICAL ACTIVITY

| Do you currently exercise? | ☐ Yes | How frequently do you exercise aerobically? | ☐ No | How long? |
|                           |       |                                           |      | min/day   |
|                           |       |                                           |      |           |
| What do you do for aerobic activity? |       |                                           |      |           |
|                           |       |                                           |      |           |
| How frequently do you strength train? |       | How long? |       |
|                           |       |                                           |      | min/day   |
| Do you have any exercise limitations? | ☐ Yes | If yes, describe | ☐ No |                      |
| What do you do for leisure activities? |       |                                           |      |           |
| Hours spent:               |       |                                           |      |           |
|                             |       | Sleeping per night |       |
|                             |       | Working per week   |       |
|                             |       | Type of work:      |       |

Please add any other information you feel may be important for the dietitian to know.