NUTRITION SERVICES
Assessment Questionnaire

UNIVERSITY HEALTH CENTER by Nebraska Medicine | University of Nebraska Lincoln

Date

Name *(Last, First)*

Preferred Name

Phone Number

Age

Gender ☐ Female ☐ Male

Race (please check all that apply)
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Unreported/ Refused to Report
☐ White

Year in School
☐ Freshman ☐ Graduate
☐ Sophomore ☐ Dental
☐ Junior ☐ Law
☐ Senior

Who referred you to our services?
☐ Advisor/Professor/TA ☐ Family Member ☐ Residence Hall Staff
☐ Campus Rec ☐ Friend ☐ Self
☐ CAPS ☐ Health Center Staff
☐ Coach/Athletic Staff ☐ Other _____

Have you seen a dietitian before?
☐ Yes If yes, who and when? _____
☐ 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 _____
☐ Vegetarian eating
☐ Want to gain weight
☐ Want to lose weight

MEDICAL HISTORY

Are you currently being treated for a medical condition?	☐ Yes ☐ Not Sure ☐ No	If yes, explain _____
Are you taking any medications or over-the-counter drugs?	☐ Yes ☐ Not Sure ☐ No	If yes, list: _____
Are you taking any supplements or herbs?	☐ Yes ☐ Not Sure ☐ No	If yes, list: _____
Do you have a family history of diabetes?	☐ Yes ☐ Not Sure ☐ No	If yes, explain _____
Do you have a family history of high cholesterol?	☐ Yes ☐ Not Sure ☐ No	If yes, explain _____
Do you have any food allergies or intolerances?	☐ Yes ☐ Not Sure ☐ No	If yes, explain _____

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
☐ No

Comments: _____

EATING BEHAVIORS

Does your food intake or your weight feel out of control? ☐ Yes ☐ No

Has your appetite changed within the last month? ☐ Yes ☐ No If yes, explain _____

How many meals do you eat per week at: _____ Home _____ Fast-Food Chain _____ Restaurant _____ Dining Hall _____ Greek house _____ Other (Please explain) _____

How would you generally describe your eating habits? ☐ Good ☐ Fair ☐ Poor

How often do you eat fewer than 3 times a day? ☐ Daily ☐ Weekly ☐ Rarely ☐ Never ☐ Almost daily

If you skip meals, which meals do you most often skip? _____

How many snacks do you eat most days? _____ Typical snacks: _____

Are you on a special diet? ☐ Yes ☐ No

Who prescribed or suggested this diet for you? ☐ Family ☐ Physician ☐ Friend ☐ Self-elected

Please specify type of diet: ☐ Diabetic ☐ Gluten free ☐ Low carb ☐ Vegetarian ☐ Other (describe) _____

BEVERAGES

Please check the beverages you consume on a typical day. When applicable, add the approximate amount consumed

☐ Reg. soda _____ ☐ Reg. coffee _____ ☐ Tea _____
☐ Diet soda _____ ☐ Decaf. coffee _____ ☐ Protein drink _____
☐ 100% fruit juice _____ ☐ Plain water _____ ☐ Energy drink _____
☐ Fruit drink/punch _____ ☐ Flavored water _____
☐ Other (please explain) _____

ALCOHOL

How often do you drink alcohol? ☐ 0-1 time/month ☐ 1-2 times/week ☐ 5+ times/week ☐ 2-3 times/month ☐ 3-4 times/week

How many drinks do you consume when you drink? ☐ Do not drink ☐ 1-2 drinks ☐ 3-5 drinks ☐ 6-8 drinks ☐ 9 or more drinks
(1 drink = 1.5 oz. liquor, 5 oz. wine, or 12 oz. beer)

TOBACCO

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

PHYSICAL ACTIVITY

Do you currently exercise? ☐ Yes ☐ No

How frequently do you exercise aerobically? _____ days/week
How long? _____ min/day

What do you do for aerobic activity? _____

How frequently do you strength train? _____ days/week How long? _____ min/day

Do you have any exercise limitations? ☐ Yes ☐ No If yes, describe _____

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