

# Nutrition Questionnaire

Student Health Care Center, GatorWell Health Promotion  
Services 392-1161, ext. 4281



Date: \_\_\_\_\_ Name: \_\_\_\_\_  
Last First (legal) Preferred First

Phone: ( ) \_\_\_\_\_ Can we leave a message at this number to remind you of your appointment  
day and time?  Y  N

Class/Major: \_\_\_\_\_ UF ID#: \_\_\_\_\_

Where do you live:  on-campus  off-campus Age: \_\_\_\_\_ Gender:  Male  Female

Referred by:  Self  Rec Center  Health care provider . . . Name? \_\_\_\_\_

Have you seen a nutritionist before?  Y  N If so, who and when? \_\_\_\_\_

Why do you want to see a nutritionist? (Check all that apply)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> General healthy eating advice | <input type="checkbox"/> Vegetarian eating   | <input type="checkbox"/> Irritable Bowel Syndrome   |
| <input type="checkbox"/> Want to lose weight           | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Disordered eating concerns |
| <input type="checkbox"/> Want to gain weight           | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Diabetes                   |

Other (please explain): \_\_\_\_\_

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Desired Weight: \_\_\_\_\_

Lowest adult weight: \_\_\_\_\_ Age or Date: \_\_\_\_\_ Highest adult weight: \_\_\_\_\_ Age or Date: \_\_\_\_\_

Does your food or weight feel out of control?..  Y  N

Are you currently being treated for a medical condition?.....  Y  N List: \_\_\_\_\_

Are you taking any medications? .....  Y  N List: \_\_\_\_\_

Are you taking any vitamin, herbal, or nutritional supplements? .....  Y  N List: \_\_\_\_\_

Do you have a family history of diabetes?.....  Y  N List: \_\_\_\_\_

Do you have any family history of high blood pressure? .....  Y  N List: \_\_\_\_\_

Do you have any family history of high cholesterol? .....  Y  N List: \_\_\_\_\_

Do you drink alcoholic beverages?.....  Y  N Describe use: \_\_\_\_\_

Sorority/Frat House?.....  Y  N List: \_\_\_\_\_

Are you currently on a special diet? (i.e., vegetarian, low-carb, gluten-free, etc).....  Y  N Describe: \_\_\_\_\_

Describe changes, if any, that you have made to your eating and/or exercise habits. When did you implement these changes?

**OVER →**

Where do you eat most often?  Campus  Home  Restaurant Other: \_\_\_\_\_

List any exercise/activity that you do on a regular basis:

Type of exercise/activity                      Days per week                      Time spent doing that activity (each time)

What do you hope to achieve as a result of nutrition counseling?

Rate how important this change is to you (0 not at all, 10 extremely) 0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time 0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

List everything you ate on:

Good Day:

Bad Day:

\_\_\_\_\_  
Your Initials

\_\_\_\_\_  
Date

**For office use: Appt:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **RD:** JM LR LL