

Nutrition Questionnaire

You have been referred to a Registered Dietitian (RD) for nutrition counseling. Please complete the forms and questions below. Answer as thoroughly as possible and bring this to your appointment. Thank you!

Patient Name: _____ **Account #:** _____

Patient Date of Birth: _____ **Appointment Date/Time:** _____

Usual Food Choices

Place a check in the column that describes how often you usually eat each food:

Foods	>2x a day	1x a day	Most days	1-3x a week	rarely	never
Beverages: Milk						
Fruit juice						
Soda pop						
Beer, wine, liquor						
Lemonade/Kool-Aid						
Sports Drinks						
Coffee/Tea						
Protein Foods						
Beef, Chicken, Pork						
Lunchmeats						
Fish						
Peanut Butter						
Beans						
Tofu/ Soy products						
Yogurt						
Cheese/cottage cheese						
Eggs						
Carbohydrate Foods:						
Bread, rolls, bagels						
Cereal (dry or cooked)						
Noodles						
Rice/other grain						
Fruit: Fresh or frozen						
Canned						
Dried						
Vegetables:						
Fresh or frozen						
Canned						
Others: Fried foods						
Butter/margarine						
Oils						
Salad dressings, mayo						
Sweets/Pastries						
Potato/corn chips						

What specific information would you like to learn during your visit with the dietitian?

Per day/week, how often do you...

1. Eat away from home/what meals? _____
2. Eat fast food? _____

What, if any, special diets have you been on? _____

Are you currently following a special diet? If so, please describe. _____

Please list any food allergies or intolerances. _____

Do you exercise? If so, what type, how many days per week, and how long is each exercise?

Please list, or bring to your appointment, any vitamin, herbal, or mineral supplements that you take:

Food Record

Please record the foods and beverages that you eat and drink for 2 days (all meals and snacks). **Include as much information as you can** about those foods and beverages, such as how much you ate (cups/ tablespoons) and how it was prepared (baked, fried, grilled), and the brand/variety/restaurant.

Day #1, Date: _____					
Morning/Breakfast	Time:	Mid-day/Lunch	Time:	Evening/Supper	Time:
Foods/Beverages consumed between meals:					
Day #2, Date: _____					
Morning/Breakfast	Time:	Mid-day/Lunch	Time:	Evening/Dinner	Time:
Foods/Beverages consumed between meals:					