Nutrition/GI Health Assessment Questionnaire

Patient Name: _____

Date of Birth: _____

1. Describe your current health lifestyle
   - ☐ Great! I follow a healthy lifestyle by _____
   - ☐ Needs work, but ready to make changes to _____
   - ☐ Needs work, but not ready to make changes
2. Describe your current weight (normal, overweight, underweight) and how you feel about it:

   _____
3. Describe your current eating habits (grazer, overeater, sugar/salt craving, balanced diet etc.)

   _____

   _____
4. What time is your first meal or beverage (besides water or black coffee)? _____

   What time is your last bite of food or drink_____
5. How much water do you drink?
   - ☐ Not sure - Not enough
   - ☐ Not sure - I think I drink enough
   - ☐ I drink ___ oz each day
6. Do you take any supplements (multi-vitamin, protein shakes etc.)?

   No : ☐

   Yes: _____

Food Frequency Questionnaire

How many days a week do you eat/drink:

- _____ Fish/seafood
- _____ Processed Sugar (cookies, ice cream, etc.)
- _____ Sugar sweetened beverage (soda, juice etc.)
- _____ Diet drink
- _____ Alcoholic beverage
- _____ Beans/Lentils
- _____ Nuts/Seeds
- _____ Berries
- _____ All other fruit
- _____ Cruciferous Vegetables (broccoli, cauliflower, brussels sprouts)
- _____ Dark Leaky Green Vegetables (spinach, kale, arugula)
- _____ Fast Food
- _____ Processed meat (bacon, sausage etc.)
- _____ Gum chewing

How many times a week do you eat out: _____

Foods you love (and cannot live without): _____

Foods you dislike: _____

Lifestyle Questions

1. How many hours of sleep on average do you get each night? _____

   How do you feel about your sleep quality/quantity? _____

2. What is "exercise" for you? _____

   How many days a week do you exercise? _____

   How many minutes a day do you spend exercising or moving? _____

3. Rate your stress on a scale of 1 to 10 (10 being the highest) _____
4. Where does stress originate (work, school, family etc.)?

   _____

5. Do you struggle with any other psychological issues (anxiety, depression, worry, loss of interest etc.)?
   - ☐ No
   - ☐ Not sure
   - ☐ Yes: _____
6. Have you ever seen a therapist/counselor/psychiatrist?
   - ☐ No
   - ☐ Yes: _____ for _____. When: _____
   - ☐ I am open to see one
7. What do you consider rest? (example: reading, going to the beach, spending time with family)

   _____

8. Have you taken antibiotics in the last year?
   a. No
   b. Yes – When?_____
9. Do you take any NSAIDs (ibuprofen, Motrin, Advil, Aleve, aspirin etc.) medication?
   a. No
   b. Yes - How frequently? _____

On a scale of 1-10, how likely are you to make dietary changes? _____

What do you need most out of this visit with the dietitian? _____

What are your top 2-3 health goals? _____

Please share any other pertinent information about diet and lifestyle

Thank you for filling out this questionnaire!

_____

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