Northwestern Memorial Physicians Group

# Nutrition Therapy Introductory Questionnaire

Date______________

Please answer the following questions to the best of your ability. Your answers will be kept confidential. This information will enable our team to address your individualized needs.

Your Name______________________________________

Primary/Referring Physician Name__________________ Phone______________ Address______________

1. Marital Status ☐ Married ☐ Never Married ☐ Separated ☐ Divorced ☐ Widowed
2. Are you: ☐ Employed (Occupation:____________________) ☐ Student
3. What is the reason for today's visit? ______________________________
4. What questions/concerns are important for us to address today?______________________________
5. What is most important for you to get out of today's visit?______________________________

## HEALTH HISTORY

**Please list your medical conditions:**

**Current medications and supplements** (please include prescribed AND over-the-counter pills, vitamin/mineral, and herbal supplements):

### If You Have Diabetes:

1. Do you have concerns about having diabetes? If so, what are your concerns? ______________________________
2. Have you seen a diabetes educator or dietitian in the past? ☐No ☐Yes (When:__________________)
3. Who manages your diabetes with you? ______________________________
4. Does your diabetes affect your: Heart ☐No ☐Yes Kidneys ☐No ☐Yes Nerves ☐No ☐Yes Eyes ☐No ☐Yes
5. Date of last eye exam ____________
6. Do you check your blood sugar at home? ☐No ☐Yes (_____times/day ____times/week Blood Sugar Range ________

Tobacco use: ☐ Never ☐ Current (How many packs per day ______? For how many years _______?
☐ Former (When did you quit smoking? _______ What method did you use to quit smoking? __________)

Do you drink alcohol? ______________ How often and how much? ______________________________

Do you take any street, club or recreational drugs? ______________________________

Average hours of sleep? _____ Restful? ☐ Yes ☐ No

How would you rate your stress level? low 1 2 3 4 5 high How do you cope with daily stressors? ______________

Who makes up your support system? ______________________________

## Weight History

Current Weight:_________ Height___________

As best as you can recall, what was your body weight at each of the following time points (if they apply)?

Grade School_____ High School______ College_____ Ages 20-29_____ 30-39_____ 40-49_____ 50-59_____ 60-69______

What was your lowest body weight as an adult? ______ What was your highest body weight as an adult? ______

## Nutrition

1. Do you have any **allergies** to medications or foods? ____________
2. Do you have any **intolerances** to foods? If so, please describe:____________
3. Do any religious or other lifestyle practices (vegetarian, vegan, raw diet) affect your health care or eating habits?____________
4. What 1 or 2 things about your eating habits would you like to change? ____________
5. Your usual eating pattern (check all that apply): ☐ Varies day to day ☐ Varies weekday vs. weekend ☐ Grazer ☐ Skip meals ☐ No pattern/random ☐ Night-time eating ☐ 3 meals/no snacks ☐ 3 meals & snacks
6. What beverages do you drink with meals and in between meals? ____________
7. How many 8-ounce glasses of water do you drink a day? ________
8. Who does the food shopping for your household?____________Who does the cooking ?____________
9. How many times you dine out weekly? ____Breakfast ____Lunch ____Dinner
10. What types of restaurants do you frequent? ____________
11. How confident are you about the *amount* of current nutrition knowledge you have? low 1 2 3 4 5 high
12. How confident are you in your ability to *apply* the current nutrition knowledge you have? low 1 2 3 4 5 high
13. How ready are you to make lifestyle changes? Not ready 1 2 3 4 5 Very ready
14. What motivates you to make healthy lifestyle changes? ____________
15. What gets in the way of making healthy lifestyle changes?____________
16. When and what do you usually eat over the course of a typical day? (Write "none" if you do not eat that meal or snack.)

| | Time | Foods/Beverages Typically Consumed |
|---|---|---|
| Breakfast | | |
| Snack | | |
| Lunch | | |
| Snack | | |
| Dinner | | |
| Snack | | |

## Physical Activity

1. Do you participate in regular exercise? _____ What activities? ____________ How often? ________
2. What physical activity would you like to do that you cannot do now? ____________

**If you are not here for weight loss, you do not need to answer any of the following questions:**

1. Why are you interested in losing weight?____________
2. At what weight or weight range do you feel the healthiest?____________
3. Are you accustomed to paying attention to your level of hunger and fullness to decide when to eat and when to stop eating? ☐ No ☐ Yes
4. Describe your cues for eating that are not related to physical hunger____________
5. Have you met with a dietitian regarding your weight? ________ Did you find it helpful? ____________
   If yes, what did you learn? ____________
6. How do you eat most of your meals? ☐ Alone ☐ With others ☐ About equal
7. Do you eat in front of TV or computer? ☐ No ☐ Yes: How frequently? ____________
8. Any life events (new job, divorce, marriage, etc) that you associate with weight gain?____________
9. Do you: (Please check all that apply).
   - ☐ Eat in response to stress?
   - ☐ Eat more rapidly than others around you?
   - ☐ Eat until feeling uncomfortably full?
   - ☐ Eat large amounts of food when you are not feeling physically hungry?
   - ☐ Eat alone because of being embarrassed by how much you are eating?
   - ☐ Feel that you cannot control the amounts you are eating or feel that you don't have the control to stop eating?
10. Eating Disorders. Do you have, or have you ever had, any of the following? (Check all that ap
    ☐ Compulsive Overeating ☐ Binge-Eating Disorder ☐ Anorexia Nervosa ☐ Bulimia Nervosa
11. Weight Loss Programs: What previous programs have you tried?

    What did you learn from these programs? ____________
    Why did you think you were successful or unsuccessful in losing and maintaining weight loss? ____________