Multi-Care Diet Questionnaire

Name: _____ Age: _____ Sex: _____ Date: _____

A. How many meals do you eat per day? _____
B. How many meals do you eat per week at a restaurant, vending machine, snack bar, fast food service, etc?
_____
_____
C. Do you work swing shift or night shift? Yes ___ No ___ *If yes, list hours:* _____
D. Do you crave salty foods? Yes ___ No ___
E. Do you crave sweets? Yes ___ No ___
F. What specific foods do you crave? _____
_____
G. Please list any foods that do not agree with you: _____
_____
H. Please indicate how many times **per week** you drink the following beverages:

Bottled water _____	Well water _____	Tap Water _____	
100% fruit juice _____	Fruit juice "cocktail" _____	Sports drink _____	
Canned veg. juice _____	Homemade veg. juice _____	Milk _____	
Chocolate milk _____	Milkshake _____	Cappuccino _____	
Lemonade _____	Reg. coffee _____	Decaff. coffee _____	
Cappuccino _____	Unsweet Tea _____	Latte _____	
Sweet tea _____	Decaff. Tea _____	Soda _____	
Diet soda _____	Beer _____	Wine _____	Liquor _____

I. Please indicate what you generally eat for each of the following meals: Please include all of the usual foods and beverages you would eat during an entire "usual" week.

BREAKFAST	
LUNCH	
DINNER	
SNACKS	

J. Do you eat between dinner and bedtime? Yes ___ No ___
K. Please list any foods that you avoid (any reason): _____
_____
L. Have you been on any of the following weight-loss diets during the past year?
Weight loss ____ Low fat ____ Diabetes ____ Low sodium ____ High Protein ____ Low Carb ____
M. Are you a vegetarian? Yes ___ No ___
N. Do you fry foods or eat fried food? Yes ___ No ___ *If yes, what type of oil is used (if known)?* _____