Tracy Taylor Wellness Services NUTRITION QUESTIONNAIRE

The time you take to provide this information will help your health care team to work better for you and is important in managing your health. All information provided is strictly confidential and will not be disclosed without your signed permission below:

I hereby authorize Tracy Taylor RDN to release this my nutritional care record for the purpose of communicating nutritional care plans with other pertinent medical care providers if necessary.

_____*Signature* _____*Date*

Print Name _____ Date of Birth_____ Sex M F

Preferred phone:_____ (A message can__cannot__ be left on this phone)

Print Name _____

Do you feel that you will be able to follow a nutrition program? □ YES □ NO

Explain_____

What are your nutrition related goals?_____

What expectations do you have working with a nutritionist?_____

How would you describe your appetite? □ Hearty □Moderate □Poor

Do you have any difficulty chewing, swallowing or digesting food? □ YES □ NO

Are you allergic to any food □ YES □ NO

if Yes, what and what happens_____

Is there any food you can't eat or drink □ YES □ NO

If Yes, what and what happens_____

Are you following any type of diet or meal plan, such as, calorie counting, carbohydrate counting, low cholesterol, paleo, gluten free, low fat or low sodium? □ YES □ NO

If yes, please describe type of diet and who recommended it:_____

Anyone else in the household on special foods/diets? _____

How many times a day do you usually eat_____? Do you skip meals? □ YES □ NO

Where do you eat most of your food? home/school/work/restaurant/other

How many people are your meals prepared for? _____

Who usually does the shopping?_____ Who usually does the cooking?_____

At home where do you eat most of your meals?_____Snacks?_____

How long does it take you to eat a meal?_____

Do you clean your plate even when full? □ YES □ NO

Do you eat when preparing food or storing leftovers? □ YES □ NO

Do your emotions/feelings affect your food choices? □ YES □ NO

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How many times each week do you eat away from home or do take-out? _____

Which meals are usually eaten away from home?

□ Breakfast □ Lunch □ Dinner

In what type of restaurant do you usually eat or "carry out"?

_____

What type of beverages do you drink each day (*circle)*:

Water Milk Juice Soda Sports drink Tea Coffee Other

Do you drink alcohol? □ YES□ NO How much?

_____What? _____

Height: _____ Present Weight: _____

Usual Weight Range: _____

How do you feel about your present weight?

□ Just Right □ Overweight □ Underweight

Skip the following questions if you answered "just right"

What would you consider to be a healthy weight for you?

_____

Have you ever tried to change your weight? □ YES □ NO

If yes, what have you tried?

_____

Have you been successful? □ YES □ NO

Are you interested in working to change your weight?

□ YES, right now □ YES, but I can't right now

□ NO, but I will think it over □ NO, not now

THANK YOU!

FOOD DIARY

Describe Your Current Eating Habits:

For a typical one day period, record your meals and snacks and beverages in the chart below. Try to estimate the **serving size**. Include the type of **cooking method** such as boiled, baked, fried, broiled or grilled. INCLUDE **BEVERAGES and condiments.**

TIME	What I eat and drink