Food Questionnaire

1. Do you eat Breakfast? Yes or No
2. How many meals do you eat in a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Which meal is your largest meal? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Are you hungry between meals? Yes or No
5. Do you have any food allergies? Yes or No
6. If so, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you have any foods that you dislike? Yes or No
8. If so, what are they? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Do you have or have you had an eating disorder? (IE: Anorexia, Bulimia, Overeating?)

Yes or No If so, what was it? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If so, are you currently under treatment by a mental health provider? Yes or No
2. If yes, how long have you been in treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do they know that you are seeking weight management help? Yes or No
4. Please list provider information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Are you currently under the care of a registered dietician or licensed nutritionist? Yes or No
6. If yes, please provide their information. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you consider yourself a healthy eater? Yes or No
8. How many servings of fruit or vegetables do you eat in a day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. Do you drink Alcohol? Yes or No
10. If so, how often? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
11. Have you used supplements? Yes or No
12. If so, what have you used and how often? (IE: multi-vitamins, protein supplements) list all

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you tired all the time? Yes or No
2. How often do you eat junk food in a week? Daily Once Multiple times weekly circle one
3. Have you ever participated in a “fad” diet? (IE: cabbage soup, Atkins, paleo, keto) Yes or No
4. What program/s? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Have you ever done a detox or fasting program? Yes or No
6. If so, which one, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
7. Do you drink 8 to 10 glasses of water a day? Yes or No
8. Do you have stomach issues? Yes or No
9. If so, explain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. How often do you have a bowel movement? Multiple times daily Daily A few times a week Please, circle one
11. Do you consider gut health important? Yes or No
12. Are you currently looking to lose weight or gain muscle? Circle one
13. If asked would a food journal be something that you would keep track with to aid in weight loss? Yes or No
14. Have you ever used intermittent fasting as weight management? Yes or No
15. Have you ever had labs to check vitamin deficiencies? Yes or NO If So, What were the results?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_