Primary Care Partners
Affiliated with
Atlantic Health System

Nutrition Counseling Intake Questionnaire

Name: _____

DOB: _____

Why do you want nutrition counseling at this time?

_____

What two main questions would you like answered during your counselling session?

1. _____

2. _____

How would you describe your appetite? Great Fair Poor No Appetite Select One

Has there been any change in your appetite? _____

How many meals do you eat away from home on weekdays? _____

How many meals do you eat away from home on the weekends? _____

Please list the restaurants where you eat often: _____

Do you exercise? Yes / No Select One

If yes, how often? What type of exercise?

_____

If no, is there a reason why you cannot or should not exercise?

_____

Has your weight changed in the past year? Yes / No Select One

If yes, how many pounds have you gained/lost? _____

Do you have any weight loss or weight gain goals? Yes / No Select One

If yes, what is your goal weight? _____

Have you ever tried weight loss diets, medication, or surgery? Yes / No Select One

If yes, please explain: _____

Do you use any meal replacement products? Yes / No Select One

If yes, what, and how often?

_____

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Do you have any food allergies? _____

Do you have any dietary restrictions? _____

Do you take any vitamin supplements? _____

Please list what you normally eat from the time you get up to when you go to bed. Please include times:

_____
_____
_____
_____
_____
_____
_____
_____
_____

On a typical day, which of these beverages do you consume and how much?

Coffee_____ Tea_____ Juice_____ Water_____

Regular Soda_____ Diet Soda_____ Alcohol_____

Milk (Skim/1%/2%/Whole) _____ Other_____

How many servings of the following do you have daily?

Fruits_____ Vegetables_____ Dairy_____

How many times per week do you eat food that is fried? _____

Which of the following do you use in cooking? (please circle)

☐Butter ☐Margarine ☐Olive Oil ☐Cooking Spray ☐Shortening/Lard ☐Coconut Oil

Do you have your own teeth or dentures/partials? (please circle) Select One

Do you have any difficulty chewing or swallowing? Yes / No (please specify) _____

Do you experience any of the following? (please circle)

☐Constipation ☐Diarrhea ☐Heartburn ☐Indigestion

How often do you typically have a bowel movement? _____

Is there anything else your registered dietitian nutritionist should know about you?

_____
_____