Kennesaw State University
Student Success Services
Health Promotion and Wellness

Nutrition Services

Nutrition Questionnaire

Please complete this form to the best of your ability and bring with you to your first nutrition counseling session.

Name: _____ Date: _____ KSU #: _____
Last First

Background Information

Email address (checked most often): _____ Phone: ( ) _____ - _____

Age: _____ Birth date: _____ Gender: □ M □ F □ Other

Year: □ Freshmen □ Sophomore □ Junior □ Senior □ Graduate Student

Major: _____

Marital status: _____ Children & ages: _____

Please list the people in your household and their relationship to you: _____

_____

Where do you live? □ On campus, please specify :_____

□ Off-campus: ___ apartment _____ with parents _____ other: _____

Referred By: □ Self □ Health Clinic □ Counseling & Psychological Services (CPS)

□ Other: _____

Have you ever seen a dietitian before? □ Yes □ No If yes, who and when? _____

Why do you want to see a dietitian? (Check all that apply)

□ Anemia	□ General healthy eating	□ Vegetarian/vegan diet
□ Diabetes	□ High blood pressure	□ Want to gain weight
□ Disordered eating concerns	□ High cholesterol	□ Want to lose weight
□ Food allergy or intolerance	□ Sport performance	□ Other: _____

General Health Information

Height: _____ Weight: _____

Physician's name: _____ Physician's phone: _____

Date of most recent physical exam: _____ Date of most recent blood tests: _____

Most recent blood test results:

Total Cholesterol _____ LDL _____ HDL _____ Triglycerides_____

Blood Pressure_____ Other:_____

How do you rate your health? _____ Poor _____ Fair _____ Good _____ Excellent

Adapted from Kushner, R.F. et al. Health Assessment Patient Questionnaire. Academy of Nutrition and Dietetics, 2009.

Please circle all that you currently have or have concerns about:

High blood pressure	Heart disease	Blood clots or clotting disorders
Ankle or feet swelling	Nausea/Vomiting	Ulcer disease
Diarrhea	Abdominal/stomach pain	Rectal bleeding/blood in stools
Heartburn/acid reflux	Hemorrhoids	Gallbladder disease/gallstones
Celiac disease	Belching/burping	Constipation
Difficulty urinating	Inability to empty bladder fully	Urinary incontinence (leaking urine)
Type 1 Diabetes	Thyroid disease	Abnormal/Absent menstrual periods
Type 2 Diabetes	High triglycerides	High cholesterol
Gout	Bruises easily	Skin sores or infections (boils, ulcers, etc)
Low energy level	Depression	Obsessive-compulsive disorder (OCD)
Bipolar disorder	Anxiety disorder/panic attacks	Psychological/psychiatric care
Binge eating	Anorexia	Bulimia
Anemia	Headaches or migraines	Cancer (list type): _____

Attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD)

Other serious medical conditions: _____

Have you recently gained or lost weight? If yes, please explain whether it was weight gain or weight loss and what changes you made that led to the change in weight. _____

_____

_____

Have you ever had concerns about your weight? □ Yes (please circle one: overweight or underweight) □ No

Comment: _____

Have you ever tried to lose weight in the past? □ Yes □ No If yes, please explain: _____

_____

Do you have a family history of any of the following (circle all that apply):

High blood pressure, high blood cholesterol, diabetes (type 1 or type 2), thyroid disease, obesity, heart disease, cancer, other (list): _____

List the types of surgeries you have had: _____

_____

How often do you use tobacco? _____ How often do you drink alcohol? _____

How many hours of sleep do you average per night? _____ Is your sleep restful? Yes No

General Health Information *continued*

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life? _____

_____

Please list any religious practices that affect your health care or diet: _____

_____

List all prescription and over-the-counter medications you currently take (include dosages):

_____

_____

_____

List all vitamins, minerals, supplements and herbs you take:

_____

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

If you are not ready to make lifestyle changes, what are the barriers preventing you from being ready?

_____

_____

On a scale of 1 (not at all confident) to 5 (very confident), how confident are you to make lifestyle changes?

1 2 3 4 5

If you do not feel very confident you can make changes, what would you need in order to become more confident?

_____

_____

Nutrition Information

What one or two things would you like to change about your diet/nutrition habits? _____

_____

_____

_____

_____

Nutrition Information *continued*

Please record all food and beverages consumed over a 24-hour time period. Remember to include snacks, desserts/ candies, and drinks. Try to record at the time you consume the food. Please estimate portion size (1 cup, 1 piece, 1 handful, etc).

Time	Amount and Type of Food/Beverage	Location/Emotions

Is this a fairly typical day for you in the time, amounts of food, and types of food(s)/beverage(s) you consume?

□ Yes □ No If no, how does it differ from a more typical eating day?

_____

_____

Physical Activity Information

What is the most physically active thing you do in an average day? _____

_____

What, if any, regular exercise(s) do you do? How often and for how long do you participate?

_____

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain reasons.

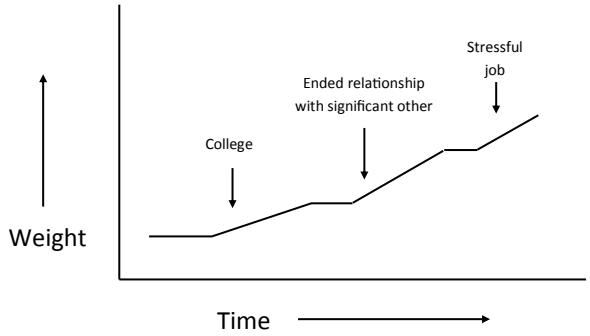
_____

_____

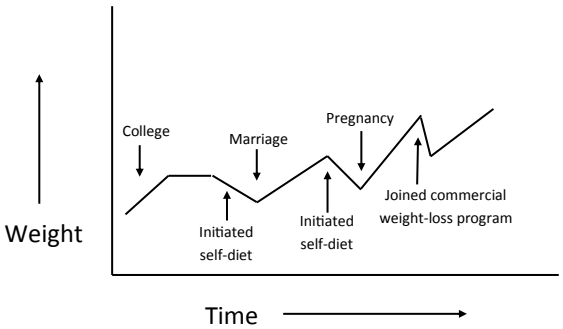
Weight History Graph

Most people can relate changes in their weight to different life events. The following graphs illustrate two examples of how people have gained weight.

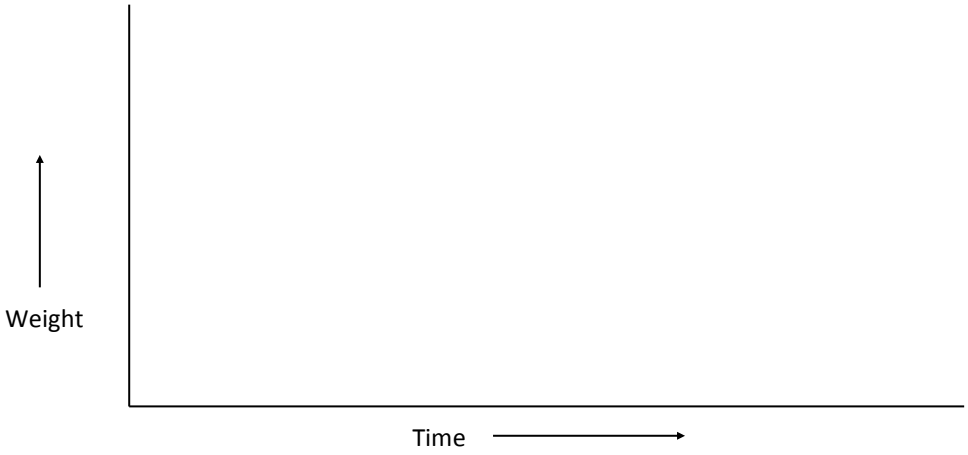
Progressive Weight Gain



Weigh Cycling/"Yo-Yo" Weight Gain & Loss



Please draw a graph describing your weight pattern. Mark life events and diet attempts that have contributed to your current weight.



By signing below, I authorize that I have read, understood and completed this questionnaire to the best of my ability.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (if student under 18 years of age) Date

Adapted from Kushner, R.F. et al. Health Assessment Patient Questionnaire. Academy of Nutrition and Dietetics, 2009.