Nutrition Questionnaire

UofL Campus Health Services 502.852.6479
UofL Health Promotion Office 502.852-1914 hlthed@louisville.edu
Form available at louisville.edu//healthpromotion

Date _____

Name _____ _____ Date of Birth__/__/____
Last First
Phone: (____) _____ e-mail _____

Year in School and Major _____ Age ____ Identify as M __ F __

Where do you live? __ off campus __ on campus Residence hall:_____
Where do you eat most often?
__ on campus Where? _____
__ restaurants Which ones? _____
__ home/apartment/residence hall
__ other: _____

Referred by __ self __ health care provider – name: _____

Why do you want to see a nutritionist? Check all that apply:

_ General healthy eating advice
_ Want to lose weight
_ Want to gain weight
_ Vegetarian eating
_ High blood pressure
_ Other: _____
_ High cholesterol
_ Diabetes
_ GI Distress/Celiac/IBS
_ Disordered eating concerns

Height _____ Current Weight _____ BMI _____
Lowest Adult Weight ____ What year? _____ Highest Adult Weight _____ Year? ____

Does your food or weight feel out of control?	__ yes __no	
Are you currently being treated for a medical condition?	__ yes __no	List:
Are you taking any medications?	__ yes __no	List:
Are you taking any vitamin, mineral, herbal or nutritional supplements?	__ yes __no	List:
Do you have a family history of diabetes, high blood pressure, high cholesterol or blood lipids?	__ yes __no	Which?
Are you currently on a special diet, i.e. vegetarian, low-carb, gluten-free, low-fat, etc.	__ yes __no	Describe:
Do you drink alcoholic beverages?	__ yes __no	Describe use:
Do you smoke?	__yes __no	Describe use:
How many hours do you sleep?	___ hours	Do you sleep well?

Describe your regular Physical Activity….

Type of activity:	Days per week?	How much time per day?

Describe changes, if any, that you have recently made to your eating and/or physical activity routines. When did you implement these changes?

_____
_____
_____
_____

What do you hope to achieve as a result of nutrition counseling?

_____
_____
_____
_____

Rate how important this change is to you: (0 = not at all 10 = extremely important)

0 1 2 3 4 5 6 7 8 9 10

Rate your confidence in making this change at this time:

0 1 2 3 4 5 6 7 8 9 10

What barriers, if any, stand in the way of you achieving your nutritional goals?

_____

Student Signature Date

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Nutritionist's Notes: