Garnet Health
MEDICAL CENTER

A Healthy Weigh

Nutrition & Eating Habits Questionnaire

Name: DOB: Date:

What is the most you have weighed? pounds What is your lowest weight as an adult? pounds

What do you think is a realistic weight for you? pounds

How many years has it been since you were at that weight? years

List all vitamin/mineral/herbal supplements:

Have you tried any diets in the past? Yes/No (If Yes, check which ones below and when.)

Type of Diet	✓	When?	Type of Diet	✓	When?
Diet Pills			***Diet Programs***		
✓ Acutrim			✓ Atkins Diet		
✓ Belviq			✓ Beach Body Containers Program		
✓ Dexatrim			✓ Intermittent Fasting		
✓ Diurex			✓ Jenny Craig		
✓ Fen-Phen			✓ Ketogenic Diet		
✓ Hydroxycut			✓ LA Weight Loss		
✓ Orlistat (Ali or Xenical)			✓ Medifast		
✓ Phentermine			✓ NutriSystem		
✓ Saxenda			✓ Optavia		
Other:			✓ South Beach Diet		
Liquid Diets			✓ Weight Watchers		
✓ Ensure/Boost			Other:		
✓ Herbalife			***Miscellaneous Diets***		
✓ Juice Cleanse			✓ Dietary Approaches to Stop Hypertension (DASH) Diet (Low Sodium)		
✓ Metracal			✓ High Protein		
✓ Optifast			✓ Low Calorie		
✓ Protein Shakes			✓ Low Carbohydrate		
✓ Shakeology			✓ Low Fat		
✓ SlimFast			✓ Military Diet		
Other:			✓ Mediterranean Diet		
Other Types of Weight Loss			✓ Portion Control		
✓ Acupuncture			✓ Vegan or Vegetarian Diet		
✓ Bariatric Surgery			***Apps***		
✓ Curves			✓ Apple Health		
✓ Hypnosis			✓ Fitbit		
✓ Lap Band			✓ Lose It		
✓ Met with a Dietitian			✓ MyFitness Pal		
✓ Overeaters Anonymous			✓ Noom		
Other:			Other:		

Eating Habits History

Typical Food & Beverage Intake

Breakfast -

Snack -

Lunch –

Snack-

Dinner -

Dessert/Snack -

Who does the grocery shopping & meal preparation in your household?

How often do you go out to eat OR order take out? ____ Multiple Times/Day ___ Daily ___ 2-3x Week

___ 1x Week ___ Rarely (1-2x/month) _____ Never

Types of Restaurants:

Do you regularly skip meals? Yes/No

Do you have financial constraints when purchasing food or grocery shop on a budget? Yes/No

Do you pay attention to your feelings of hunger and fullness? Yes/No

Do you use food to cope with your emotions? Yes/No

What is the reason you go off of a diet or stop following a diet or exercise program?

Barriers: What gets in the way of you reaching your food/nutrition/exercise goals? (Ex: time, knowledge deficit, etc.)

On a Scale of 1-10, 1 being the lowest and 10 being the highest, how confident do you feel you are ready to make lifestyle changes right now?

1 2 3 4 5 6 7 8 9 10

Physical Activity & Sleep History

Do you currently exercise? Yes/No

Is there any reason you cannot exercise?

Types of Exercise: (check all that apply)

___ Walking ___ Aerobics ___ Dance ___ Running ___ Cycling ___ Team Sports ___ Yoga ___ Weight Lifting ___ Swimming ___ Tennis ___ Racket Ball ___ Rowing ___ Hiking ___ Rollerblade ___ Pilates ___ Kick Boxing/MMA ____Basketball ____ Crossfit Other:

How often? ___ Daily ___Once /Week ___ 2-3 Times/Week _____4-5 Times/Week ___ Less than once/week

Duration: ___ 10-15 minutes ___ 20-30 minutes ____ 30-45 minutes ____ 45-60 minutes ____ 60-90 minutes ____ 90+ minutes

Do you have difficulty falling asleep or sleeping through the night? ___ Every night ___ Some nights ___ Rarely ___ Never

How many hours of sleep do you get most nights?

What factors do you feel have contributed to your weight gain? (Ex: pregnancy, medication, injury, depression, etc.)

Is there anything else you want the Registered Dietitian to know or be aware of?