Student Health Services, SHS @ Dixon, 211 Dixon Recreation Center
Oregon State University, Corvallis, Oregon 97331
Tel 541-737-7556 | **General Fax** 541-737-7721 | **Medical Fax** 541-737-9665 |
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Nutrition and Health Information Questionnaire

Please fill out this form to the best of your ability. The more detail you provide, the more we can tailor our time together to meet your individual nutrition needs and goals. All responses are confidential. Please come prepared to describe your eating patterns over the past 24 hours.

Name: _____ Student ID#: _____

Age: _____ Height:_____ Weight: _____ Gender: _____

Primary Reason for Visit: _____

Referred by: ____ Self ___ Clinician ___ Counseling & Psychological Services (CAPS)
____ Other: _____

Medical/Health History

Please list any past or current medical conditions that you have or are currently being treated for:

_____

_____

List any medications you are currently taking: _____

_____

Do you have any food allergies or medically diagnosed intolerances? Y / N (Circle one)
If yes, please list: _____

Do you take any vitamin/mineral/herbal/sports supplements? Y / N (Circle one)
If yes, please list: _____

Do you smoke? Y / N (Circle one) If yes, how often/how much: _____

Do you drink alcohol? Y / N (Circle one) If yes, how often/how much: _____

Please rate your daily stress level:

1 2 3 4 5 6 7 8 9 10
Low Stress High Stress

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

_____

Food & Nutrition History

How many times a day do you typically eat: _____

Do you consume caffeinated beverages on a regular basis? (Check all that apply)
____ Coffee ____ Tea ____ Soda ____ Energy Drinks

Do you avoid any of the following foods? (Check all that apply)

____ Red meat	____ Fruits	____ Sweets (candy, desserts)
____ Poultry (chicken, turkey)	____ Fried food	____ Alcohol
____ Fish	____ Breads	____ Fats/oils (mayo, dressing, butter)
____ Dairy (milk, cheese)	____ Grains (pasta, rice)	
____ Vegetables	____ Fast food	

Foods you especially like: _____

Foods you especially dislike: _____

Weight History

Has your appetite changed recently? Y / N (Circle one)
If yes, please describe: _____
_____

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

Have you ever had concerns about your weight? Y / N (Circle one)
___ Underweight ___ Overweight
Comment: _____

Have you ever tried to lose or gain weight in the past? Y / N (Circle one)
If yes, please describe: _____
_____

Overall, how satisfied are you with the physical appearance of your body? (Check one)

____ Very satisfied	____ Somewhat dissatisfied
____ Somewhat satisfied	____ Very dissatisfied

Physical Activity History

Are you currently physically active? Y / N (Circle one)
If yes, How often: _____ times per week
How long: _____ minutes per session
Type of activities: _____

Please rate the average intensity of your workouts: (Circle one)

Light	(walking slowly, sitting, standing)
Moderate	(walking briskly, heavy cleaning, light bicycling)
Vigorous	(hiking, running, fast bicycling, most team sports, weight lifting)

Nutrition Goals

What nutrition-related goals do you have? What eating habits would you like to work on?

_____
_____
_____

How important is it to you to make changes in your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant Very Important

How confident are you in your ability to improve your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant Very Important