Nutrition Questionnaire

UofL Campus Health Services| UofL Health Promotion Wellbeing Central | UofL Dining Services

Form Available: http://louisville.edu/healthpromotion or http://louisville.edu/dining

Name: _____ Date:_____
LAST FIRST

BACKGROUND INFORMATION

E-mail _____ Phone: (_____)_____

Date of Birth ____/ _____/____ Age: ____ Gender: □ M □ F □ Other

Year in School _____ Major: _____

Where do you live? □ On Campus, Residence Hall/Apartment Name: _____

□ Off Campus: ____ Apartment _____ with parents _____ other: _____

Referred By: □ Self □ Campus Health □ Counseling Center □ Other:_____

Have you ever seen a Dietitian before? □ Yes, who and when? _____ □ No

NUTRITION ASSESSMENT

Where do you eat *most often*?

□ On Campus – Where?_____

□ Restaurants—Which Ones? _____

□ Home/Apartment/Residence Hall

□ Other: _____

□ How confident do you feel about preparing and cooking new foods and recipes?
On a scale from 0-10 (0 = not at all confident 10 = extremely confident) _____

What do you want to address in your nutrition coaching session(s)? **CHECK ALL THAT APPLY:**

□ General Healthy Eating Advice
□ Want to Lose Weight
□ Want to Gain Weight
□ Vegetarian/ Vegan
□ Disordered Eating Concerns
□ High Cholesterol
□ Diabetes
□ High Blood Pressure
□ GI Distress/Celiac/IBS
□ Improved Mood/Sleep
□ Improved Fitness
□ Learn how to grocery shop
□ Learn how to prepare meals
□ Other: _____

In the last year, have you gained or lost weight? If yes, please explain: _____

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

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

Are you currently being treated for a medical condition?	□ Y □ N	List:
Are you taking any medications?	□ Y □ N	List:
Are you taking any vitamin, mineral, herbal or nutritional supplements?	□ Y □ N	List:
Do you have a family history of diabetes, high blood pressure, high cholesterol or blood lipids?	□ Y □ N	Which?
Do you drink alcoholic beverages?	□ Y □ N	Describe use:
Do you smoke? ***(all forms)***	□ Y □ N	Describe use:

Does your food or eating feel out of control?	□ Y □ N	
Does your body weight feel out of control or confusing?	□ Y □ N	
Are you currently on a special diet, i.e. vegetarian, vegan, low-carb, gluten-free, low-fat or other	□ Y □ N	Describe:
How many hours do you sleep on weekdays? How many hours do you sleep on weekends? Do you nap? If so, how many minutes/hours?	____ Hrs ____ Hrs ____ min/hrs	Do you sleep well?

PHYSICAL ACTIVITY ASSESSMENT:

TYPE OF ACTIVITY	DAYS PER WEEK?	HOW MANY MINUTES OR HOURS EACH TIME?

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 important----- 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 = not at all confident ----- 10 = extremely confident)

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?

******OFFICE USE ONLY*******

In cooperation with Campus Health, are you in agreement that this questionnaire will be scanned into your medical chart?

□ Accept □ Decline

_____

Student Signature Date