QUESTIONNAIRE TO COMPLETE (BOTH SIDES) BEFORE MEETING THE DIETITIAN

PERSONAL DATA

DATE :_____
FIRST NAME :_____
MAIDEN NAME :_____
MARRIED NAME:_____
DATE OF BIRTH :_____ AGE : _____ YRS
ADDRESS :_____
CITY :_____
POSTAL CODE :_____
TEL. (HOME) :_____
TEL. (WORK) :_____
OCCUPATION :_____
CIVIL STATUS :___ SINGLE ___ MARRIED ___ C.LAW
OF CHILDREN :_____ AGES: _____
REFERENCE :_____
IF PREGNANT :_____ th WEEK

PERSONAL INFORMATION

HEIGHT :_____
CURRENT WEIGHT :_____
DESIRED WEIGHT :_____
BMI :RESERVED FOR THE DIETITIAN :_____
HEALTHY WEIGHT :RESERVED FOR THE DIETITIAN :_____

WHAT IS THE REASON FOR YOUR CONSULTATION ?
_____

WHAT DO YOU THINK ARE THE REASONS FOR YOUR CURRENT SITUATION ?
_____

WHO IS YOUR CURRENT DOCTOR ? Dr_____
MEDICAL CLINIC :_____
CITY :_____ TELEPHONE :_____

WHAT PROBLEMS ARE PRESENT IN YOUR FAMILY ?
(DIABETES, CVD, OVERWEIGHT, OBESITY, OTHERS)
FATHER :_____
MOTHER :_____
BROTHER(S) :_____
SISTER(S) :_____

WHAT OPERATIONS HAVE YOU HAD IN THE PAST ?
_____

WHAT HEALTH PROBLEMS HAVE YOU HAD ?
_____

ARE YOUR BLOOD VALUES NORMAL ? _____ YES
_____ NO, SPECIFY : _____

WHAT ARE YOUR EXPECTATIONS REGARDING THE DIETITIAN ?_____
_____

MISCELLANEOUS DATA

WHAT PHYSICAL ACTIVITIES DO YOU DO ? _____
_____
_____ MINUTES PER WEEK

WHAT MEDICATIONS DO YOU TAKE ?
NAME DOSE REASON
_____
_____
_____
_____

DO YOU TAKE SUPPLEMENTS (vitamins, minerals, natural products, etc.) ?
_____

DO YOU SMOKE ? ___ NO
___ YES : ___CIGARETTES/ DAY

DO YOU SUFFER FROM CONSTIPATION ?
_____NO _____ YES _____ STOOLS/ WEEK

HOW MANY GLASSES OF WATER (250 mL) ? _____ PER DAY

HOW MUCH TIME DO YOU ALLOW FOR MEALS ?
BREAKFAST :_____ MINUTES
LUNCH :_____ MINUTES
SUPPER :_____ MINUTES

WHEN DO YOU HAVE SNACKS ?
_____ AM _____ PM _____ EVENING

ARE YOUR EATING HABITS GENERALLY ?
_____ GOOD _____ AVERAGE _____ MEDIOCRE

DO YOU EAT 3 MEALS PER DAY ? _____ YES _____ NO
IF NOT, WHICH DO YOU SKIP ? _____

DO YOU EAT ? ____ SLOWLY ____ FAIRLY FAST___ FAST

WHAT ARE THE CRITICAL MOMENTS WHEN YOU EAT MORE ? _____
_____

HOW MANY MEALS PER WEEK DO YOU EAT AWAY FROM HOME ?
_____CAFETERIA _____ LUNCHES _____RESTAURANTS
_____OTHERS : _____

HOW MANY SOCIAL OUTINGS PER WEEK ?____OUTINGS
TYPE(S) :_____

WHAT ACTIVITIES DO YOU DO WHILE EATING?
___ WATCH TV ___ READ ___ LISTEN TO RADIO___ TALK ___ WRITE

Complete the other side, thank you !

QUESTIONNAIRE TO COMPLETE (BOTH SIDES) BEFORE MEETING THE DIETITIAN

WRITE DOWN WHAT YOU EAT DURING A USUAL DAY
(DO NOT COMPLETE IF DONE ON ANOTHER SHEET)

BREAKFAST : TIME :____PLACE_____

_____

_____

_____

SNACK AM :_____

LUNCH : TIME :_____PLACE_____

_____

_____

_____

_____

_____

_____

SNACK PM :_____

SUPPER : TIME :_____PLACE_____

_____

_____

_____

_____

_____

_____

_____

SNACK EVENING :_____

Times of snacks : AM:____PM:____EVENING:_____

TO COMPLETE IF YOU WANT TO LOSE WEIGHT

DESCRIBE YOUR WEIGHT HISTORY AND YOUR HISTORY OF DIETING:

START OF WEIGHT GAIN:_____YEARS

STAGE IN LIFE:_____

CAUSES OF YOUR WEIGHT GAIN:_____

_____

HIGHEST WEIGHT :_____AT_____YEARS
LOWEST :_____AT_____YEARS
MOST STABLE :_____AT_____YEARS

PAST DIETS FOLLOWED :

AGE	DIET FOLLOWED	STARTING WEIGHT	END WEIGHT	LENGTH OF MAINTENANCE

FOOD CHOICES / HABITS

BEEF, VEAL, POULTRY, FISH, ALTERNATIVES, ETC.:

Your choices in order:_____
___ serving(s) of fish per week
___ egg(s) per week
___ tablespoon(s) (15 mL) peanut butter per week
___ slice(s) of delicatessen products per week
___ serving(s) of chickpeas, lentils, etc., per week
COMMENTS :_____

VEGETABLES:* _____*fresh* ____*canned* ___*frozen

Your choices in order:_____
A normal portion is:_____ cup(s) per meal
COMMENTS :_____

BREADS, RICE, PASTA, POTATO, CEREALS:

Your choices in order:_____
___ slice(s) of bread per day___ white ___ whole grains
___ potato(es) per day ____ per week
Types of cereals:_____
COMMENTS :_____

FRUITS:* _____*fresh* _____*canned

Your choices in order:_____
___ fruit(s) per day ____ glass(es) (250mL) juice/day
COMMENTS :_____

MILK, YOGURT, CHEESE, MILK PRODUCTS:

Your choices in order:_____
___ cup(s) of milk per day __ 0% __ 1% __ 2% __3%
Types of cheese(s):_____
COMMENTS :_____

FAT (butter, marg., nut oil, olive oil, dressing, etc.):

Your choices in order:_____
___ tsp(s) of fat per day ___ butter ___ margarine
___ slice(s) of bacon per week
COMMENTS :_____

OTHER FOODS:

___ coffee(s) or tea(s) ____ tisane(s) per day
___ without sugar ____ sugar(s) per day
___ with milk ____ with cream per day
___ soft drink(s) ___ reg. ___ diet per week
___ glass(es) of wine ____ aperatifs per week
___ ounce(s) of alcohol ___ beer(s) per week
___ pastry(ies)/baked goods (cake, pie...) per week
___ cookie(s) per week:_____
___ chocolate(s) per week:_____
___ serving(s) of chips per week
Cooking: _____ with fat or _____ without fat
Salt : _____ none _____ little _____ medium ____ a lot