Kennesaw State University
Health Promotion and Wellness

Nutrition Questionnaire

Please complete this form to the best of your ability and bring with you to your first nutrition counseling session.

Name: _____ Date: _____ KSU #: _____

Email Address (checked most often): _____ Phone: ( ) _____ -_____

Age: _____ Birth date: _____ Gender: ☐ Male ☐ Female ☐ Other: _____

Year: ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior ☐ Graduate

Major: _____

Marital Status: _____ Children & Ages: _____

Please list the people in your household/apartment and their relationship to you:

_____

Where do you live?

☐ On Campus, please specify: _____
☐ Off Campus, please specify: ☐ Apartment
☐ With Parents
☐ Other: _____

Referred by: ☐ Self ☐ Health Clinic ☐ Counseling & Psychological Services (CPS)
☐ Other: _____

Have you ever seen a dietitian before? ☐ Yes ☐ No

If yes, who and when? _____

Why do you want to see a dietitian? (Check all that apply)

☐ Anemia	☐ General Healthy Eating	☐ Vegetarian/Vegan Diet
☐ Diabetes	☐ High blood pressure	☐ Want to gain weight
☐ Disordered Eating Concerns	☐ High Cholesterol	☐ Want to lose weight
☐ Food allergy or intolerance	☐ Sport performance	☐ Other: _____

General Health Information

Height: _____ Weight: _____
Food Allergies/Intolerances: _____
Current Medications: _____
Current Supplements (includes multivitamins/multiminerals, protein, etc) _____
_____

Medical History

Date of most recent blood tests: _____

Total Cholesterol _____ LDL _____ HDL _____ Triglycerides _____

Blood Pressure _____ Other: _____

Surgical History (please list type of surgery and the date): _____

Do you have a family history of any of the following (check all that apply):

☐ High Blood Pressure	☐ Diabetes Type 1	☐ Diabetes Type 2
☐ Thyroid Disease	☐ Obesity	☐ Heart Disease
☐ Cancer	☐ Other: _____	

How would you rate your health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Please check all that you currently have or have concerns about:

☐ High Blood Pressure	☐ Nausea/Vomiting	☐ Anorexia Nervosa
☐ Heart Disease	☐ Abdominal pain	☐ Bulimia Nervosa
☐ High Triglycerides	☐ Heartburn/ Acid Reflux	☐ Binge Eating Disorder
☐ High Total/LDL Cholesterol	☐ Diarrhea	☐ Depression
☐ Low HDL Cholesterol	☐ Constipation	☐ Anxiety/Panic Attacks
☐ Anemia: _____	☐ Hemorrhoids	☐ Personality Disorder
☐ Type I Diabetes	☐ Crohn's/Irritable Bowel Syndrome	☐ Obsessive Compulsive Disorder
☐ Type 2 Diabetes	☐ Rectal bleeding/blood in stool	☐ ADD/ADHD
☐ Celiac Disease	☐ Abnormal/absent menstrual cycle	☐ Headaches/migraines
☐ Blood clots	☐ Thyroid disease	☐ Low energy levels
☐ Ankle/feet swelling	☐ Gallbladder disease/gallstones	☐ Other: _____

Have you recently gained or lost weight? If yes, please explain. _____

_____

Have you ever had concerns about your weight? ☐ No ☐ Yes

If Yes, please specify: ☐ Overweight ☐ Underweight

Comment: _____

Have you ever tried to lose weight in the past? ☐ No ☐ Yes

If yes, please explain: _____

Do you ever make yourself sick because you feel uncomfortably full? ☐ No ☐ Yes

Do you ever use exercise to compensate for calories/food you have eaten? ☐ No ☐ Yes

Do you worry that you have lost control over how much you eat? ☐ No ☐ Yes

Do you believe yourself to be fat when others say you are too thin? ☐ No ☐ Yes

Would you say that food dominates your life? □ No □ Yes

How many hours of sleep do you average per night? _____

Is your sleep restful? □ Yes □ No

On a scale from 1 (low stress) to 5 (high stress), how would you rate your daily stress level?

1 2 3 4 5

How do you cope with stress in your daily life?

_____

Please list any religious practices or beliefs that influence your health care or diet:

_____

On a scale of 1 (not ready) to 5 (very ready), how ready are you to make lifestyle changes?

1 2 3 4 5

What barriers prevent you from being ready for lifestyle change? _____

_____

On a scale of 1 (not confident at all) to 5 (very confident), how confident are you that you could make lifestyle changes?

1 2 3 4 5

What do you need in order to become more confident?

_____

What one or two things would you like to change about your diet/nutrition habits?

_____

_____

Physical Activity Information

What is the most physically active thing you do in an average day?

_____

What, if any, regular exercise(s) do you do? How often and for how long do you participate?

_____

Do you know of any reason(s) why you should not do physical activity? If yes, please explain.

_____

In the chart below, please record all food and beverages you consumed the previous day. Please include snacks, desserts, candies as well as drinks. Try to record at the time that you consume the food. Please estimate portion sizes (1 cup, 1 piece, 1 handful, etc).

Time	Amount and Type of Food/Beverage	Location, Emotions

Is this a fairly typical day for you in the time, amounts of food, and types of foods/beverages you consume? ☐ Yes ☐ No

If no, how does it differ from a more typical eating day?

_____

_____

By signing below, I authorize that I have read, understood and completed this questionnaire to the best of my ability.

_____ _____

Student Signature Date

_____ _____

Parent/Guardian Signature (if student under 18 years of age) Date