Health Promotion and Wellness

Nutrition Screening Questionnaire

Name: ___________________________ Date: __________ KSU#: ______________________________

Email Address (checked most often):______________________ Phone:______________________________

Age:_______ Birth Date:_____________________ Gender: ☐ Male ☐ Female ☐______________

Please check all that you currently have:

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ High Triglycerides
- ☐ High Total/LDL Cholesterol
- ☐ Low HDL Cholesterol
- ☐ Anemia:________________
- ☐ Type I Diabetes
- ☐ Type 2 Diabetes
- ☐ Celiac Disease
- ☐ Blood clots
- ☐ Ankle/feet swelling

- ☐ Nausea/Vomiting
- ☐ Abdominal pain
- ☐ Heartburn/ Acid Reflux
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Crohn's/Irritable Bowel Syndrome
- ☐ Rectal bleeding/blood in stool
- ☐ Abnormal/absent menstrual cycle
- ☐ Thyroid disease
- ☐ Gallbladder disease/gallstones

- ☐ Anorexia Nervosa
- ☐ Bulimia Nervosa
- ☐ Binge Eating Disorder
- ☐ Depression
- ☐ Anxiety/Panic Attacks
- ☐ Personality Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ ADD/ADHD
- ☐ Headaches/migraines
- ☐ Low energy levels
- ☐ Other: ________

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

Have you lost more than 14 lbs. in 3 months? ☐ No ☐ Yes

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