

Nutrition Questionnaire

Student Health Care Center, GatorWell Health Promotion Services 392-1161, ext. 4281

*Initial assessment may be conducted in a small group of up to 4 students. All follow-ups are conducted as individual appointments.



Date: _____ Name: _____
Last First (legal) Preferred First

Phone: () _____ Can we leave a message at this number to remind you of your appointment day and time? Y N

Class/Major: _____ UF ID#: _____

Where do you live: on-campus off-campus Age: _____ Gender: Male Female

Referred by: Self Rec Center Health care provider . . . Name? _____

Have you seen a nutritionist before? Y N If so, who and when? _____

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

- | | | |
|--|--|---|
| <input type="checkbox"/> General healthy eating advice | <input type="checkbox"/> Vegetarian eating | <input type="checkbox"/> Irritable Bowel Syndrome |
| <input type="checkbox"/> Want to lose weight | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Disordered eating concerns |
| <input type="checkbox"/> Want to gain weight | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Diabetes |

Other (please explain): _____

Height: _____ Current weight: _____ Desired Weight _____

Lowest adult weight: _____ Age or Date: _____ Highest adult weight: _____ Age or Date: _____

Does your food or weight feel out of control?.. Y N

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, herbal, or nutritional supplements? Y N List: _____

Do you have a family history of diabetes?..... Y N List: _____

Do you have any family history of high blood pressure? Y N List: _____

Do you have any family history of high cholesterol? Y N List: _____

Do you drink alcoholic beverages?..... Y N Describe use: _____

Do you smoke cigarettes?..... Y N Describe use: _____

Are you currently on a special diet? (i.e., vegetarian, low-carb, gluten-free, etc)..... Y N Describe: _____

Where do you eat most often? Campus Home Restaurant Other: _____

List any exercise/activity that you do on a regular basis:

<u>Type of exercise/activity</u>	<u>Days per week</u>	<u>Time spent doing that activity (each time)</u>
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OVER →

Describe changes, if any, that you have made to your eating and/or exercise habits. 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, 10 extremely) 0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time 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?

Student Signature Date

Nutritionist's Notes:

Plan:

- | | |
|---|---|
| <input type="checkbox"/> Student to call for follow-up prn. | <input type="checkbox"/> Complete Food Journal for min of ____ days |
| <input type="checkbox"/> Student to reschedule in ____ week(s). | <input type="checkbox"/> Complete hunger/satiety scale. |
| <input type="checkbox"/> Reschedule now for appt in ____ week(s). | <input type="checkbox"/> Handout given: _____ |
| <input type="checkbox"/> Return for Eating Issues assessment. | <input type="checkbox"/> Meal Plan: _____ |
| <input type="checkbox"/> Refer to physician. | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Refer to mental health. | <input type="checkbox"/> _____ |

Dietitian Signature _____ Date _____

For office use: Appt: ____/____/____ RD: JM LR LL