Lifestyle Questionnaire

Name_____ E-mail address_____
How were you referred to this service? _____
Who is your primary care physician if different than above? _____

Do You Want to Change Your Lifestyle?

Have you made any changes in your lifestyle that you feel good about?
___ Yes ___ no It yes, what changes have you made? _____

If yes, who will support and encourage you as you make these changes? _____
_____

If no, what would keep you from making these changes? _____

What information would you like from the nutritionist?

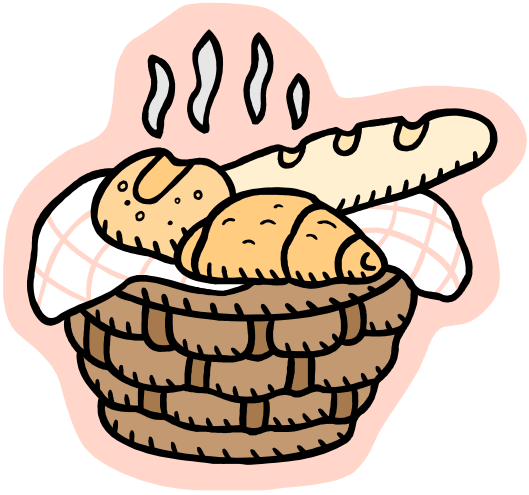
- ❑ Meal planning
- ❑ Eating out
- ❑ Reading food labels/supermarket shopping
- ❑ Weight management
- ❑ Exercise
- ❑ Record keeping
- ❑ Other

What changes would you like to make?

- ❑ Improve my eating habits
- ❑ Improve my activity level
- ❑ Improve my blood glucose control
- ❑ Lower my blood pressure
- ❑ Improve my cholesterol/triglyceride levels

Nutrition Consultant

- ❑ Learn how to manage my weight
- ❑ Improve my energy level
- ❑ Control food cravings
- ❑ Feel better about my health
- ❑ Other



Jean Hoppe, R.D.

Nutrition History

- Have you ever wanted to make changes in what you eat? ____ Yes ___No
If yes, what advice have you been given? _____

- Are you following any type of meal plan, such as exchange lists, calorie counting, carbohydrate or fat counting, low cholesterol or sodium? ____Yes ____No
If yes, please describe_____

- How many people live in your household? _____ Ages_____

- Who usually does the cooking? _____The shopping? _____

- Do you eat out? ____Yes ____No How often? _____
Check the types of restaurants where you normally eat.
  - ❑ Fast food
  - ❑ Buffets/All you can eat
  - ❑ Sit-down restaurant (Names: _____)

- Do you drink alcohol? ___Yes ____No
If yes, what type? _____Beer ____Wine ____Liquor

- Do you take vitamins, minerals, herbs, or any other food or nutritional supplement? ____Yes ____No If yes, please list _____

- Do you regularly skip meals? ____Yes ____No If yes, list which meals you skip most often and why. _____

- Do you have "trigger" foods that often cause you to overeat? ____Yes ____No
If yes, please list. _____

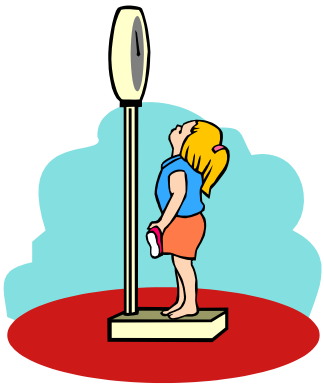
- Do you eat for other reasons than hunger? ____Yes ____No
If yes, please describe_____

- Do you snack? ____Yes ____No When do you usually snack? _____

- Do you engage in other activities when you eat? _____

- Do you read labels? ____Yes ____No what do you look for on labels? _____

_____



Weight History

- Height _____ Present weight _____ Usual weight _____
  BMI_____

- Has your weight changed any over the past year? ____Yes ____No

  If yes, please describe how _____

  How do you feel about your weight now? _____

- What has been your weight range as an adult _____

What would you consider to be a healthy weight for you? _____

  Would you feel comfortable at that weight? ____Yes ____No

- Have you ever tried to change your weight before? ____Yes ____No

  If yes, what have you tried? _____
  _____
  Have you been successful? _____

- Are you interested in working to change your weight?

  - ❑ Yes, right now
  - ❑ Yes, but I can't right now
  - ❑ No, but I will think it over
  - ❑ No, not now
  - ❑ No, I'm not interested

Physical Activity History

- What type of activities do you do regularly and how much time each week do you spend doing them? Examples include walking, dancing, golf, tennis, biking, aerobics and swimming.

Activity	Times per week	Minutes per activity

- Do you like to do these activities alone or with others? _____

- Do you perform other physical activities of daily living, such as housework, gardening, or climbing stairs? If yes, list type and amount _____
_____
_____

- Are you interested in becoming more physically active?
  - ❑ Yes, right now
  - ❑ Yes, but I can't right now
  - ❑ No, but I will think it over
  - ❑ No, not now
  - ❑ No, I'm not interested

If yes, what type of physical activity could you see yourself doing regularly?

_____