namaste nutrition

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Nutrition Consultation Questionnaire

Name _____ **Date of Visit**_____

How did you hear about Namaste Nutrition?

Online search _____ (specify search terms _____)

Medical provider _____ Other_____

WEIGHT HISTORY

HEIGHT	WEIGHT	HIGHEST ADULT WEIGHT	WEIGHT AT 18-20 YEARS	GOAL WEIGHT

***Dietitian will make the following calculations*:**

BMI	IBW	ABW	DAILY CALORIES Lose / Gain	DAILY CALORIES (Maintain)

To change eating behaviors, which of these, if any, have you tried? ***Check all that apply.***

a. Dietitian / nutritionist Y____ N____
b. Low calorie / very low calorie diet Y____ N____
c. Group diet program (i.e., Weight Watchers, OA) Y____ N____
d. Prescription or over-the-counter diet drugs Y____ N____
e. Psychological counseling / behavior modification Y____ N____
f. Induced vomiting or used laxatives Y____ N____
g. Engaged in excessive exercise Y____ N____
h. Excessively restricted calories Y____ N____

Do family members have body or eating issues? *(Circle those that apply.)* Father Mother Brother(s) Sister(s)

Do you… ***Check all that apply.***

Eat differently when you are **alone**? Y____ N____
Eat sweets or salty **snacks**? Y____ N____
Eat **snacks vs meals** throughout the day? Y____ N____
Tend to **binge eat** at times? Y____ N____
Eat in front of the **TV** or **computer**? Y____ N____
Eat meals or snacks in the **car**? Y____ N____
Ever feel emotionally uncomfortable after eating? Y____ N____
Tend to **eat 50% or more** of your daily intake after 6pm? Y____ N____

How much time do you think about food, eating, and exercise? _____%
How comfortable are you with the way you eat? _____%

How do you feel when you see your body? 1 2 3 4 5

Extreme dislike Neutral Extreme Like

MEDICAL HISTORY:
Check all medical conditions that apply to ***you***.

a. Diabetes (Type 1, 2, GDM) Y____ N____
b. High blood pressure Y____ N____
c. High cholesterol Y____ N____
d. Arthritis / joint pain Y____ N____
e. Sleep apnea / asthma Y____ N____
f. Heartburn (GERD) Y____ N____
g. Gallbladder / gallstones Y____ N____
h. Liver disease Y____ N____
i. Kidney disease Y____ N____
j. Eating disorder Y____ N____
k. History of cancer: Y____ N____
Specify_____
l. Thyroid Y____ N____
m. Menopause *(completed)* Y____ N____
n. Pregnancy (*currently*) Y____ N____
o. Menstruation: Y____ N____
Specify regularity_____
p. PCOS Y____ N____
q. Surgery: _____ Y____ N____
r. Digestive health issues: Y____ N____
– Irritable bowel syndrome _____
– Stomach ulcers _____
– Ulcerative colitis _____
– Crohn's disease _____

Please list all vitamin and herbal products:

_____
_____
_____

Please list all present prescription medications/doses:

_____
_____
_____
_____
_____
_____

Please list all *allergies* or *intolerances* (i.e., lactose):

To any foods_____
_____
_____
_____

To any medications_____
_____
_____
_____

Do you smoke? Y____ N____ **Quantity?** _____
If you quit, for how long? _____

Are you a Night Owl _____, Early Bird _____ or Neutral _____?

Number of hours of sleep each night?_____

EATING PATTERNS:
Please pick the number that best describes how much these behaviors may influence your weight.
1 = Contributes a small amount
2 = Contributes a moderate amount
3 = Contributes a large amount

_____a. Eat too much food
_____b. Eat not enough food
_____c. Snack between meals
_____d. Snack while cooking meals
_____e. Snack after dinner
_____f. Eat because hungry
_____g. Intense cravings
_____h. Cannot stop once I've begun
_____i. Eat because I'm not full
_____j. Eat because it tastes good
_____k. Eat when anxious
_____l. Eat when tired
_____m.Eat when bored
_____n. Eat when stressed
_____o. Eat when angry
_____p. Eat when depressed
_____q. Eat when socializing or happy

Please write any other factors that you feel may have contributed to your feelings about your body and weight.

_____
_____
_____
_____

How many days a week do you eat the following meals?

Meal	Days per week	Time
Morning meal		
Morning snack		
Midday meal		
Afternoon snack		
Evening meal		
Nighttime snack		

Who prepares meals?_____

Who meal plans? _____

Who grocery shops?_____

Describe your appetite:

___ Strong, must eat when hungry.
___ Variable, sometimes hungry or not; forget to eat if busy.
___ Not hungry a lot; OK if I eat just a couple times a day.

Please list the amount of the following you typically have in a day.

_____Milk _____whole _____2% _____1%
_____Seltzer water or club soda
_____Water
_____Tonic water or soft drinks *(diet or regular)*
_____Vitamin Water, flavored water, Gatorade
_____Energy drinks *(Red Bull, Rockstar, Monster)*
_____Fruit juice
_____Coffee — Cream? ___Sugar?___Decaf?___
_____Tea *(black, green or herbal)*
_____Alcohol *(5 oz wine, 12 oz beer, 1.5 oz liquor)*

During a typical week, how many meals do you eat at a fast-food / quick serve restaurant or coffee shop?

Breakfast: _____ meals per week
Lunch: _____ meals per week
Dinner: _____ meals per week

During a typical week, how many meals do you eat at a traditional restaurant or cafeteria?

Breakfast: _____ meals per week
Lunch: _____ meals per week
Dinner: _____ meals per week

How willing are you to record *(online or paper)* **what you eat and drink?**

1 Very **2** **3 Neutral** **4** **5 Not Very**

24-HOUR FOOD RECALL: **Please write down all the foods and drinks you had yesterday.**

Meal	**Time**	**Food/drink** *(include how prepared)*	**Amount**	**Where did you eat this?**
Morning Meal				
Snack				
Midday Meal				
Snack				
Evening Meal				

PHYSICAL ACTIVITY:

What physical problems, if any, limit physical activity?

_____

_____

How much do you enjoy physical activity?

a. Not at all _____
b. Moderately _____
c. Greatly _____

Please check the types of activity you have participated in during the last 3 months.

a. Walking / hiking *(outside or treadmill)*
b. Jogging / running
c. Elliptical / arc trainer
d. Yoga *(gentle, hatha, power, vinyasa, heated)*
e. Group exercise classes *(Barre, step, spin)*
f. Biking *(outside or indoors)*
g. DVD exercises at home *(P90X, YogaGlo)*
h. Swimming or water aerobics
i. Personal training *(one-on-one or group)*
j. CrossFit, Pilates, indoor rowing, Curves
k. Dancing
l. Strength training / weight lifting

Please circle the best response below (relative to the *past 3 months*):

FREQUENCY (total activity)

_____ 6 - 7 times per week
_____ 3 - 5 times per week
_____ 1 - 2 times per week
_____ A few times per month

INTENSITY (per activity)

_____ Aerobic activities that result in heavy breathing and sweating *(e.g., high impact aerobics, running, speed swimming, distance cycling)*.
_____ Moderate aerobic activity *(e.g., normal bike riding, jogging, low impact aerobics)*.
_____ Moderate aerobic activity *(e.g., moderate speed walking)*
_____ Light aerobic activity *(e.g., normal walking, golf)*.

TIME (per activity)

_____ Over 30 minutes
_____ 30 minutes
_____ Under 30 minutes

READINESS CHECKLIST:

Who, if anyone, is supportive of your decision to engage in different behaviors around food, body, and exercise?

_____
_____
_____
_____

How important is it that you make these changes now?
Pick a number between 1 and 10 in which:

1 = "not at all important" and
10 = "greatest importance"

My number = _____

How confident or able make these changes?
Pick a number from 1 to 10 in which:

1 = "not at all confident" and
10 = "extremely confident"

My number = _____

What are the top benefits of making these changes?

_____
_____
_____
_____
_____
_____
_____

What are the down sides of making these changes?

_____
_____
_____
_____
_____
_____
_____

Any other thoughts or insights related to these changes?

_____
_____
_____
_____
_____
_____

If you decide to make the choice to change your behaviors around food, body, and exercise, which of the following, if any, would work best for you?

_____ Increase / reduce physical activity
_____ Know how to eat at restaurants
_____ Eat more colorful fruits & vegetables
_____ Spend less money at coffee shops
_____ Expand on foods that are nourishing
_____ Learn more about meal preparation
_____ Get to know my sweet tooth better
_____ Reduce TV / movies watching / screen time
_____ Stop body checking / weighing yourself
_____ Spend more time with friends and family
_____ Reduce stress / more relaxation
_____ Understand amount of food my body needs

Circle the <u>top 5 values</u> that are most important to you as you live your life. ***There's no moral implication for only 5 choices!***

Appreciation	Education	Humor	Pleasure
Authenticity	Energy	Independence	Professionalism
Balance	Excellence	Innovation	Prosperity
Beauty	Faith	Integrity	Purposefulness
Career	Family	Joyfulness	Respect
Clarity	Financial security	Leadership	Responsibility
Commitment	Fitness	Loyalty	Self-esteem
Compassion	Friends/social life	Parenting	Spirituality/religion
Connection	Generosity	Patience	Steadiness
Courage	Gratitude	Perseverance	Teamwork
Creativity	Health	Personal growth	Unconditional Love
Curiosity	Honesty	Playfulness	Wisdom