



Nutrition Consultation Questionnaire

Name _____ Date of Visit _____

How did you hear about Namaste Nutrition?

Online search _____ Therapist _____

Medical provider _____ Other _____

WEIGHT HISTORY

HEIGHT	WEIGHT	HIGHEST ADULT WEIGHT	WEIGHT AT 18-20 YEARS	DESIRED WEIGHT
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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 program (i.e., Weight Watchers, OA, FAA) 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 ___ Sister

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 (*anorexia, bulimia, binge eating, etc.*) Y ___ N ___
- k. History of cancer: Y ___ N ___
Specify _____
- l. Thyroid (*hypo/hyper*) Y ___ N ___
- m. Menopause (*completed*) Y ___ N ___
- n. Perimenopause Y ___ N ___
- o. Pregnancy (*currently*) Y ___ N ___
- p. Menstruation: Y ___ N ___
Specify regularity _____
- q. PCOS Y ___ N ___
- r. Digestive health issues: Y ___ N ___

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 _____ **or an Early Bird** _____

How many hours do you 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 2 3 4 5
 Very Neutral Not Very

24-HOUR FOOD RECALL:

Please write down all the foods and drinks you had yesterday.

Meal	Time	Food/drink (<i>include how prepared</i>)	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 (*outside or treadmill*)
- 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, Down Dog*)
- h. Swimming or water aerobics
- i. Personal training (*one-on-one or group*)
- j. CrossFit, Pilates, indoor rowing, Curves
- k. Dancing
- l. Strength training / weightlifting

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 choose to change your thoughts and behaviors around food, body and exercise, which of the following, if any, would work best for you? Please list them in order of priority, i.e., 1, 2, 3, etc.

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

Circle the top 5 values 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 |

Thank you for taking time to complete this questionnaire. When we meet, we will continue the journey you've started!