namaste nutrition

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Lifestyle Questionnaire

Name _____ **Visit Date**_____

Thank you for reaching out!! How did you hear about Namaste Nutrition?

Online search _____ Therapist (name) _____

Medical provider (name) _____ Other (name)_____

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

Dietitian / nutritionist	Y____ N____
Calorie restriction	Y____ N____
Group or 12-step program (Weight Watchers, OA, FAA)	Y____ N____
Prescription diet medications	Y____ N____
Psychological counseling / behavior modification	Y____ N____
Induced vomiting	Y____ N____
Laxative use	Y____ N____
Exercise	Y____ N____

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

Do you… ***Check all that apply.***

Eat differently when alone?	Y____ N____
Eat snacks vs meals throughout the day?	Y____ N____
Binge eat at times?	Y____ N____
Intentionally eat less at times?	Y____ N____
Eat in front of the TV?	Y____ N____
Eat meals or snacks while working or on a computer?	Y____ N____
Engage in emotional eating (stress, sadness, anger, etc.)	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 daily do you spend thinking about eating and exercise? _____%

How comfortable are you with the way you eat? _____ Very _____ Somewhat _____Not at all

What would you change? _____

_____

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***.

Diabetes (Type 1, 2, GDM) _____
High blood pressure _____
Cholesterol concerns _____
Arthritis / joint pain _____
Sleep apnea / asthma _____
Heartburn (GERD) _____
Gallbladder / gallstones _____
Liver disease _____
Kidney disease _____
Eating disorder *(anorexia, bulimia, binge eating, etc.)* _____
History of cancer: _____
*Specify*_____
Thyroid (*circle Hypo/Hyper*)_____
Menopause *(completed)* _____
Perimenopause _____
Pregnancy (*currently*) _____
Menstruation: _____
PCOS _____
Digestive health issues _____

Vitamin and herbal products:

_____
_____
_____

Prescription medications/doses:

_____
_____
_____
_____
_____

Allergies **or** ***intolerances*** **(i.e., lactose or gluten):**

To foods_____
_____
_____

To medications_____
_____
_____

Do you smoke? Y____ N____ **Quantity? _____**

Are you a **Night Owl** _____ or an **Early Bird** _____

Describe your sleep experiences:

_____
_____
_____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

Who meal plans?_____

Who grocery shops?_____

Who prepares meals?_____

Describe your appetite:

_____ Strong, must eat when hungry.
_____ Variable, forget to eat if busy.
_____ OK if I eat just a couple times a day.

What's your willingness to record *(online or paper)* **what you eat and drink?**

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

You may be curious about changing your dietary choices, sleeping habits, physical activity, stress management, and other aspect of well-being. If so,

Who may be supportive of these changes?
Any downsides to these?
Any thoughts or insights related to these changes?

_____
_____
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Give me an idea of a typical day for you related to eating:

Meal	**Time of day or night**	**Food / drink**
Morning Meal		
Snack		
Midday Meal		
Snack		
Evening Meal		
Snack		

PHYSICAL ACTIVITY: Please check how often you've engaged in these activities over the last 3 months.

_____Walking *(outside or inside)*
_____Jogging / running *(outside or inside)*
_____ Hiking
_____Biking
_____Elliptical
_____Yoga
_____Gym group classes
_____Swimming
_____Personal training
_____CrossFit, Pilates
_____Kayak / Indoor rowing
_____Dancing
_____Strength training / weightlifting
_____Other