Garnet Health
MEDICAL CENTER

A Healthy Weigh

Nutrition & Eating Habits Questionnaire

Name: DOB: Date:

What is the most you have weighed? pounds What is your lowest weight as an adult? pounds

What do you think is a realistic weight for you? pounds

How many years has it been since you were at that weight? years

List all vitamin/mineral/herbal supplements:

Have you tried any diets in the past? Select one (If Yes, check which ones below and when.)

Type of Diet	✓	When?	Type of Diet	✓	When?
Diet Pills			***Diet Programs***		
✓ Acutrim	☐		✓ Atkins Diet	☐	
✓ Belviq	☐		✓ Beach Body Containers Program	☐	
✓ Dexatrim	☐		✓ Intermittent Fasting	☐	
✓ Diurex	☐		✓ Jenny Craig	☐	
✓ Fen-Phen	☐		✓ Ketogenic Diet	☐	
✓ Hydroxycut	☐		✓ LA Weight Loss	☐	
✓ Orlistat (Ali or Xenical)	☐		✓ Medifast	☐	
✓ Phentermine	☐		✓ NutriSystem	☐	
✓ Saxenda	☐		✓ Optavia	☐	
Other:			✓ South Beach Diet	☐	
Liquid Diets			✓ Weight Watchers	☐	
✓ Ensure/Boost	☐		Other:		
✓ Herbalife	☐		***Miscellaneous Diets***		
✓ Juice Cleanse	☐		✓ Dietary Approaches to Stop Hypertension (DASH) Diet (Low Sodium)	☐	
✓ Metracal	☐		✓ High Protein	☐	
✓ Optifast	☐		✓ Low Calorie	☐	
✓ Protein Shakes	☐		✓ Low Carbohydrate	☐	
✓ Shakeology	☐		✓ Low Fat	☐	
✓ SlimFast	☐		✓ Military Diet	☐	
Other:			✓ Mediterranean Diet	☐	
Other Types of Weight Loss			✓ Portion Control	☐	
✓ Acupuncture	☐		✓ Vegan or Vegetarian Diet	☐	
✓ Bariatric Surgery	☐		***Apps***		
✓ Curves	☐		✓ Apple Health	☐	
✓ Hypnosis	☐		✓ Fitbit	☐	
✓ Lap Band	☐		✓ Lose It	☐	
✓ Met with a Dietitian	☐		✓ MyFitness Pal	☐	
✓ Overeaters Anonymous	☐		✓ Noom	☐	
Other:			Other:		

Eating Habits History

Typical Food & Beverage Intake

Breakfast -

Snack -

Lunch –

Snack-

Dinner -

Dessert/Snack -

Who does the grocery shopping & meal preparation in your household?

How often do you go out to eat OR order take out? Select one

Types of Restaurants:

Do you regularly skip meals? Select one

Do you have financial constraints when purchasing food or grocery shop on a budget? Select one

Do you pay attention to your feelings of hunger and fullness? Select one

Do you use food to cope with your emotions?

What is the reason you go off of a diet or stop following a diet or exercise program?

Barriers: What gets in the way of you reaching your food/nutrition/exercise goals? (Ex: time, knowledge deficit, etc.)

On a Scale of 1-10, 1 being the lowest and 10 being the highest, how confident do you feel you are ready to make lifestyle changes right now? Select one

Physical Activity & Sleep History

Do you currently exercise? Select one

Is there any reason you cannot exercise?

Types of Exercise: (check all that apply)

☐ Walking ☐ Aerobics ☐ Dance ☐ Running ☐ Cycling ☐ Team Sports ☐ Yoga ☐ Weight Lifting ☐ Swimming ☐ Tennis ☐ Racket Ball ☐ Rowing ☐ Hiking ☐ Rollerblade ☐ Pilates ☐ Kick Boxing/MMA ☐ Basketball ☐ Crossfit Other:

How often? Select one

Duration: Select one

Do you have difficulty falling asleep or sleeping through the night? Select one

How many hours of sleep do you get most nights?

What factors do you feel have contributed to your weight gain? (Ex: pregnancy, medication, injury, depression, etc.)

Is there anything else you want the Registered Dietitian to know or be aware of?