

Dietary/Nutrition
Questionnaire

Client Name:

Date:
(month) - (day) - 2011

**www.
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1050 Meadows Dr.,
Suite 304
Round Rock, TX 78681



Trainer/Instructor:

OTHER DETAILS?
(List additional details below that may be pertinent to your nutrition programming)

- Questionnaire Contents:**
1. General Data
 2. Food Frequency Questionnaire
 3. Lifestyle Information-Additional Information

GENERAL DATA

1. Height: _____
2. Usual Weight: _____ Actual Weight: _____
3. Have you had a recent weight loss of greater than 10 pounds in the last 30 days?
Yes _____ No _____
4. Have you been on a weight reduction diet? _____ Yes _____ No
5. Have you had a recent change in appetite? _____ Yes _____ No
6. Do you have specific problems with:
 - a. Swallowing _____yes_____no
 - b. Chewing _____yes_____no
 - c. Nausea _____yes_____no
 - d. Vomiting _____yes_____no
7. Do you currently follow any specific diet? _____
 - a. If yes, explain: _____
8. What "diets" have you tried in the past? *(Please list details of name, length, difficulties, and likes)*
 - a.
 - b.
 - c.
 - d.
9. Are you allergic to any foods? _____
10. Do you take any vitamin or mineral supplements? _____
11. Do you take any other medications? _____
12. Please list everything you have eaten in the past 24 hours and time of consumption to the best of your knowledge: *(list item, details of item, location while consuming, and time of day consumed)*

FOOD FREQUENCY QUESTIONNAIRE

1. Do you drink milk? _____
 - a. If so, how much? _____
 - b. What kind? _____
2. Do you use fat? _____ If so, how much? _____
3. How often do you eat meat? _____ Eggs? _____ Cheese? _____ Beans? _____
4. Do you eat snack foods? _____ If so, which ones? _____

 - a. How often? _____
 - b. How much? _____
5. Which vegetables in each group do you eat? (*highlight those you do like*)
 - a. Broccoli, green peppers, cooked greens, carrots, sweet potatoes, raw cabbage, Asparagus, beets, cauliflower, corn, cooked cabbage, celery, peas, lettuce
6. Which fruits do you eat? (*highlight those you do like*)
 - a. Tomatoes, Apples, apple sauce, apricots, bananas, berries, cherries, grapes, grape juice, peaches, pears, pineapple, plums, prunes, raisins, Oranges, orange juice, grapefruit, grapefruit juice
7. Breads & Cereals
 - a. How much bread do you usually eat with each meal?
 - i. _____
 - b. How much bread between meals? _____
 - c. Do you eat cereal? _____ Daily _____ Weekly _____ No
 - d. What types of cereal do you eat if so? _____
 - e. How often do you eat foods such as macaroni, spaghetti, & noodles? _____
 - f. Do you eat whole-grain breads & cereals? _____ If yes, how often? _____
8. Do you use these and how often:
 - a. Salt _____
 - b. Sugar _____
9. Do you eat dessert? _____ How often? _____
10. Do you drink coke, coffee, or tea? _____ If yes, how often? _____

11. Do you eat candy or cookies? _____ If yes, how often? _____

12. Do you use sugar substitutes? _____
13. Do you drink alcohol? _____ How often? _____

LIFESTYLE INFORMATION-ADDITIONAL INFORMATION

1. What obstacles have you encountered in past efforts to eat healthier, diet, or lose weight? (*type below*)

2. In consideration of family obligations, work, and other lifestyle aspects that you encounter on a regular basis, what obstacles do you foresee as a possible roadblock/difficulty? (*type below*)

- 3. Have you carried a food log/journal in past efforts? Will keeping a food journal/log be difficult for you to begin now?

- 4. Please list people in your life that will be helpful for support of your lifestyle and nutrition changes:
 - a. Please list people in your life that could possibly hinder your choice to make a lifestyle and nutrition change:

- 5. Do you have a habit of skipping meals? If so, which ones most often?

- 6. If previously active in fitness/exercise, what do you normally eat prior to a workout?
(list here) _____
 - a. What do you normally eat after a workout?

- 7. Do you have any family history or do you-yourself have any of the following:
 - a. Diabetes? _____ (list type)
 - b. Hypothyroidism? _____
 - c. Hyperthyroidism? _____
 - d. Obesity/Overweight? _____

- 8. In the past, where have you looked to for nutrition advice/recommendations? (*friend, family, magazines, TV, websites, etc.*)

- 9. How comfortable are you with reading and understanding food labels?
(scale 1-5, 1=horrible ; 5=excellent)

- 10. Do you or have you ever had problems with:
 - a. Stress Eating?

 - b. Social Eating (gatherings, only eating badly because everyone else is)?

 - c. Eating Out (fast food, restaurants, etc.)?

 - d. Other?