



Nutrition Program Questionnaire

Date: _____ Phone # _____

Name: _____ Email: _____

What is your current weight? _____ What would you like to weigh? _____

How would you rate the activity of your day to day life? (Non-exercise)

Sedentary Moderate Active Active Very Active

Do you have a health issues that might prevent you from changing your current eating habits?

Yes No If YES what are they? _____

What is your goal?

Weight Loss Maintain/ Improve Eating Habits Gain Weight

If your goal is weight loss:

Are you more than 20 pounds overweight? Yes No

Has your doctor ever said that you need to lose weight? Yes No

What is the most you have weighed as an adult? _____

What is the least you have weighed as an adult? _____

Have you lost and regained weight? Yes No

Have you tried diets before? Yes No

Have you had any negative diet experiences? Yes No

Do you have parents or siblings who are overweight? Yes No

Have you ever had a body composition test done? Yes No

How important is it to achieve your weight loss goal? (Circle one, 10 being very important)

1 2 3 4 5 6 7 8 9 10

Which of the following statements best describes you? (pick one)

I can eat practically anything and I do not gain weight. I find it very hard to gain weight.

My weight fluctuates easily and it is hard for me to maintain a healthy weight.

I find it difficult to lose weight. I can gain weight easily and have to watch what I eat.

Rate from number 1 – 10 (10 the best). Circle the number that best corresponds to your attitude about your body.

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|---------------|---|---|---|---|---|---|---|---|---|----|
| a) Strong | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| b) Hearty | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| c) Healthy | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| d) Attractive | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| e) Fit | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Do you have any health related issues due to being overweight? Yes No

What are they? _____