



Eating Questionnaire

Name _____

Date _____

Your answers to this questionnaire will help us in formulating your diet and your maintenance eating style. Please answer as completely and as honestly as you can. This information will become a part of your confidential medical record. We may ask that you fill this out again in the future to assess changes in your eating style. If you find there isn't enough space for your answer, add an asterisk* and finish your answer at the end.

1. Have you ever had nutritional training in prior weight loss programs?
Yes, No. If so, describe. (include training in prior weight loss programs) _____

2. Have you had formal nutritional training? Yes, No. If yes, please describe: _____

3. Do you think the food pyramid is an appropriate way for you to eat?
Yes, No.
4. Do you try to follow the food pyramid eating style? Yes, No.
5. When considering your daily food intake, do you eat: normal amounts , more than normal amounts , less than normal amounts .
6. Breakfast:
 - a. Do you eat breakfast? Yes, No.
 - b. If so, what time do you usually eat breakfast? _____
 - c. What is your favorite breakfast? List items and quantities:

 - d. How often do you eat breakfast? Every day , if not how many days/week? _____
 - e. What protein do you eat at breakfast? _____
 - f. Do you have another favorite breakfast? If so, what?

 - g. How often do you eat this favorite? _____
 - h. Does your breakfast change with the season? Yes, No.
 - i. If your breakfast changes with the season, describe.

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7. Lunch

- a. Do you eat lunch? Yes, No.
- b. If so, what time do you usually eat lunch? _____
- c. What is your favorite lunch? List items and quantities.

- d. How often do you eat lunch? Every day , if not how many days/week?

- e. What protein do you eat at lunch? _____
- f. Do you have another favorite lunch? If so, what? _____
- g. How often do you eat this favorite? _____
- h. Does your lunch change with the season? Yes, No.
- i. If your lunch changes with the season, describe. _____

8. Dinner

- a. Do you eat dinner? Yes, No.
- b. If so, what time do you usually eat dinner? _____
- c. What is your favorite dinner? List items and quantities. _____

- d. How often do you eat dinner? _____
- e. What protein do you eat at dinner? _____
- f. Do you have another favorite dinner? Yes, No. If so, what?

- g. How often do you eat this favorite? _____
- h. Does your dinner change with the season? Yes, No.
- i. If your dinner changes with the season, describe. _____

- j. Do you have dessert after dinner? Yes, No.
- k. If so, what do you typically have? _____

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9. Snacks

- a. Do you eat snacks? Yes, No.
- b. If so, what time do you eat snacks? _____
- c. What is your favorite snack? List items and quantities. _____

- d. How often do you eat this favorite? _____
- e. What protein do you eat for a snack? _____
- f. Do you have another favorite? Yes, No. If so, what? _____

- g. How often do you eat this favorite? _____
- h. Do your snacks change with the season? Yes, No.
- i. If your snacks change with the season, describe. _____

- j. Is there a time of day when you when you eat more, have cravings, lose control or is a problem with eating in any way? Yes, No.

10. If so, describe. _____

11. Stress eating: Everyone has some kind of stress in their lives. When you are under stress - do you eat more, or less, than usual? If more, what?

12. Depression:

- a. Are you ever depressed? Yes, No.
- b. When you are depressed do you eat more, or less, than you normally do?
- c. If you eat more, what do you eat? _____

- d. How often does this happen? every day, most days, once weekly, _____

13. a. *For women only:* Does your appetite or your eating change according to your menstrual cycle? Yes, No.

b. Do you have cravings at certain times in your cycle? Yes, No.
Describe _____

14. What foods do you eat that you think may be a problem for your weight or for your health? _____

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15. What foods do you eat that are beneficial for your weight or for your health? _____
16. Do certain things you eat have a tendency to trigger more eating or trigger cravings that create a problem? Yes, No. If so, describe. _____
17. Binging means eating a greater quantity of food in a given amount of time than you think is normal.
- Do you ever binge eat? Yes, No.
 - If so, when is the last time you had a binge? _____
 - What and how much did you eat? _____
 - How often do you binge? _____
 - Have you had binge eating in the past? Yes, No.
18. People who binge-eat often feel out-of-control while binging and then have remorse afterwards.
- Do you feel like you sometimes have no control over your eating? Yes, No.
 - Do you sometimes have feelings of remorse after eating? Yes, No.
19. Bulimia: Are you or have you ever been a bulimic? Yes, No.
20. Anorexia nervosa: Are you or have you ever been an anorexic? Yes, No.
21. Has there ever been a time in your life when you ate improperly? Yes, No. Describe. _____
22. Are you a nighttime eater? Yes, No.
23. Are you a refrigerator raider? Yes, No.
24. Do you always eat sitting down? Yes, No.
25. Where do you eat at home? Which rooms do you eat in? Describe. _____
26. Do you skip meals? Yes, No. Describe. _____
27. Some people seldom really stop eating but continually nibble on something throughout the day or a part of the day, evening or night. Sometimes such people will eat discrete meals and sometimes not. This is called grazing. Do you sometimes graze? Yes, No. Describe. _____
28. Protein here means animal protein (meat, eggs or dairy). How many times per day do you eat a serving of protein?

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29. Name your three favorite restaurants, and describe your favorite choice at each. _____

30. Name your three favorite fast food establishments and describe your favorite choice at each. _____

31. List 10 food choices that you like to eat in the order you prefer them with your favorite first. _____

32. List 10 food choices that you dislike or will not eat in order with something you hate first. _____

33. Vitamins:

a. Do you take vitamins? Yes, No.

b. If so, what? _____

c. Bring them in so we can read the labels when we review this form with you.

34. Prescription medications:

a. Do you take any prescription medications that affect your eating or your weight? Yes, No.

b. If so, describe. _____

35. Over-the-counter medications

a. Do you take any over-the-counter medicines or supplements that affect the way you eat or your weight? Yes, No.

b. If so, describe. _____

36. Alcohol:

a. Do you drink alcoholic beverages? Yes, No.

b. If so, what? _____

c. How much per day? _____

d. How often? _____

e. Have you ever been an alcoholic? Yes, No.

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37. Recreational drugs:

- a. Do you use recreational drugs? Yes, No.
- b. Have you ever used them in the past? Yes, No.
- c. If so, what? _____
- d. Have you ever been addicted to any drug? Yes, No.

38. Please keep and return to us a food diary for three non-dieting days.

Below is an example of what information we want to see:

(If this is you, we have a *lot* of work to do!)

| Time | Meal/Snack | Items | How much? |
|-------|------------|---------------------------------------------------------------|---------------------------------------------------------------|
| 7 AM | Breakfast | Orange juice Bagel Coffee & Cream | 8 oz One 2 cups |
| 10 AM | Snack | Donut | 3 |
| noon | Lunch | Hamburger Fries Soft drink | Whopper Large serving 32 oz |
| 3 PM | Snack | Pizza | One medium |
| 6 PM | Dinner | Steak Baked potato Beer Apple pie & ice cream | 14 oz large with butter & sour cream 4 2 servings |
| 9 PM | Snack | Cookies Ice cream | 12 2 cups |