



Student Health Services, SHS @ Dixon, 211 Dixon Recreation Center
 Oregon State University, Corvallis, Oregon 97331
 Tel 541-737-7556 | General Fax 541-737-7721 | Medical Fax 541-737-9665 |
studenthealth.oregonstate.edu/

Nutrition and Health Information Questionnaire

Please fill out this form to the best of your ability. The more detail you provide, the more we can tailor our time together to meet your individual nutrition needs and goals. All responses are confidential. Please come prepared to describe your eating patterns over the past 24 hours.

Name: _____ Student ID#: _____

Age: _____ Height: _____ Weight: _____ Gender: _____

Primary Reason for Visit: _____

Referred by: ___ Self ___ Clinician ___ Counseling & Psychological Services (CAPS)
 ___ Other: _____

Medical/Health History

Please list any past or current medical conditions that you have or are currently being treated for:

List any medications you are currently taking: _____

Do you have any food allergies or medically diagnosed intolerances? Y / N (Circle one)

If yes, please list: _____

Do you take any vitamin/mineral/herbal/sports supplements? Y / N (Circle one)

If yes, please list: _____

Do you smoke? Y / N (Circle one) If yes, how often/how much: _____

Do you drink alcohol? Y / N (Circle one) If yes, how often/how much: _____

Please rate your daily stress level:

1	2	3	4	5	6	7	8	9	10
Low Stress									High Stress

How do you cope with stress in your daily life? _____

Food & Nutrition History

How many times a day do you typically eat: _____

Do you consume caffeinated beverages on a regular basis? (Check all that apply)

___ Coffee ___ Tea ___ Soda ___ Energy Drinks

Do you avoid any of the following foods? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Red meat | <input type="checkbox"/> Fruits | <input type="checkbox"/> Sweets (candy, desserts) |
| <input type="checkbox"/> Poultry (chicken, turkey) | <input type="checkbox"/> Fried food | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Fish | <input type="checkbox"/> Breads | <input type="checkbox"/> Fats/oils (mayo, dressing, butter) |
| <input type="checkbox"/> Dairy (milk, cheese) | <input type="checkbox"/> Grains (pasta, rice) | |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Fast food | |

Foods you especially like: _____

Foods you especially dislike: _____

Weight History

Has your appetite changed recently? Y / N (Circle one)

If yes, please describe: _____

Have you recently gained or lost weight? If yes, please explain whether it was a gain or loss and what changes led to the change in weight. _____

Have you ever had concerns about your weight? Y / N (Circle one)

Underweight Overweight

Comment: _____

Have you ever tried to lose or gain weight in the past? Y / N (Circle one)

If yes, please describe: _____

Overall, how satisfied are you with the physical appearance of your body? (Check one)

- | | |
|---|--|
| <input type="checkbox"/> Very satisfied | <input type="checkbox"/> Somewhat dissatisfied |
| <input type="checkbox"/> Somewhat satisfied | <input type="checkbox"/> Very dissatisfied |

Physical Activity History

Are you currently physically active? Y / N (Circle one)

If yes, How often: _____ times per week

How long: _____ minutes per session

Type of activities: _____

Please rate the average intensity of your workouts: (Circle one)

- | | |
|----------|---|
| Light | (walking slowly, sitting, standing) |
| Moderate | (walking briskly, heavy cleaning, light bicycling) |
| Vigorous | (hiking, running, fast bicycling, most team sports, weight lifting) |

Nutrition Goals

What nutrition-related goals do you have? What eating habits would you like to work on?

How important is it to you to make changes in your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant

Very Important

How confident are you in your ability to improve your nutrition habits? (Please circle)

1 2 3 4 5 6 7 8 9 10

Unimportant

Very Important