



Registered Dietitian Nutritionist
Certified Diabetes Educator
Certified Intuitive Eating Counselor

Family Nutrition History Questionnaire

Family Name _____ Date of Consult _____
Home Phone _____ of Adults _____ of Children _____

MOTHER

Name _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Phone (work) _____ (cell) _____ Email _____
Personal Physician _____ Phone _____
Address _____

FATHER

Name _____ Birthdate _____ Age _____
Occupation _____ Employer _____
Phone (work) _____ (cell) _____ Email _____
Personal Physician _____ Phone _____
Address _____

CHILDREN

<u>Name</u>	<u>Age</u>	<u>Grade</u>	<u>Present in Session?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Pediatrician _____ Phone _____
Address _____

For each question, check the response which best describes the family's usual eating behavior.

1. Are there any diet restrictions followed in the home? Yes No
 If yes, what type:

<input type="checkbox"/> Low Sodium	<input type="checkbox"/> Low Fat
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Weight Management
<input type="checkbox"/> Bland	<input type="checkbox"/> Low Cholesterol
<input type="checkbox"/> Other _____	

2. Have there been any recent changes made in the family's food intake or dietary pattern?
 Yes No
 If yes, indicate what and when _____

3. Does anyone in the family have any food allergies? Yes No
 If yes, please list whom and which foods: _____
 Describe what happens when the food is eaten: _____

4. Is breakfast a meal eaten daily? Yes No
 How many days per week? 6-7 days 3-5 days 1-2 days None

5. How would you describe the family's eating habits?
 Regular Irregular

6. How many meals are eaten per day? _____

7. How often are between meal/after meal snacks eaten?
 Daily
 Several times a week
 Once a week or less
 Seldom eat in between meals
 Name the snacks that are kept in the home: _____

8. What is the usual pattern for the evening meal?
 Biggest meal
 Medium size meal
 Light meal

9. What types of food do your meals typically include?

- Red meats
- Fish or Chicken, but no red meats
- Vegetarian meals with milk, eggs or cheese
- Completely vegetarian meals- no animal products

10. What are the methods of meat preparation most often used?

- Fried Roasted Stewed
- Baked Broiled Boiled

11. Not counting juices, approximately how many servings of fruit are usually eaten per day or per week? # ____ per day week

12. Not counting tossed salads or potatoes, approximately how many servings of vegetables are usually eaten per day or per week? # ____ per day week

13. How do you usually cook vegetables?

- In water Steam Stir Fry Microwave
- Other _____

14. What vegetable seasonings do you use most often?

- Butter Pepper Salt Margarine Creamed None
- Other _____

15. Are ready-to-eat breakfast cereals regularly consumed? Yes No

If yes, what kind(s) of cereal do you buy most often? _____

16. What kind of fat(s) do you usually use for cooking?

- Real butter
- Vegetable oil; Type: _____
- Vegetable shortening
- Margarine; Brand: _____
- Lard or bacon fat
- Vegetable oil spray
- Don't know

17. What kind of table spread(s) do you usually use?

- Real butter Don't know
- Spread that is ½ butter, ½ margarine
- Stick margarine; Brand: _____
- Tub margarine; Brand: _____
- Low fat margarine; Brand: _____

18. Do you normally use convenience foods, such as packaged dry mixes, frozen dinners, or canned entrees? Yes No
 If yes, list some examples: _____

19. Do you use "health" foods or special dietetic products? Yes No
 If yes, list some examples: _____

20. How many meals per week are eaten away from the home? _____
 Where? (i.e. office, restaurant, school, friend's home) _____

21. In the household, who plans the meals? _____
 Buys the food? _____
 Prepares the meals? _____

22. For how long do you normally store fresh fruits and vegetables?

23. How often are fried foods eaten (such as french fries, fried fish or chicken)?
 Daily
 1-3 times per week
 4-6 times per week
 less than once a week

24. Does the family follow any special religious or cultural practices that affect food intake?
 Yes No
 If yes, please describe: _____

25. Do any family members take vitamin, mineral or other nutrition supplements?
 Yes No If yes, please describe:

<u>Name</u>	<u>Type</u>	<u>How often taken</u>	<u>Dose</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

26. Please list the number of cups of water each family member drinks per day:

<u>Name</u>	<u>Number of cups</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

27. What other beverages are kept in the house? (i.e. juice, soda...)

28. Please list how often and what type of exercise each family member participates in per week:

<u>Name</u>	<u>Type</u>	<u>Times per week</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

29. Please indicate any particular concerns or questions you may have about the family's food choices and eating habits.

30. List nutrition goals that you would like to achieve from Family Nutrition Counseling.

