Elite Health & Fitness Training, Inc.

FOOD HISTORY QUESTIONNAIRE

Name: ______________________________ Date: _____________

Height: _________ Weight: _________ Age: _________ Sex: _________

Weight History: ____

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Have you ever tried to lose weight before or are you currently trying to lose weight? If yes, explain:

____

____

Do you currently follow a specific diet? If yes, explain:

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____

Have you ever used laxatives for weight control? YES NO

Have you ever vomited for weight control? YES NO

Medical History: ____

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Medications: ____

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Have you ever been advised by your physician to follow any type of diet? YES NO

Eating Habits: The following are questions about your typical eating pattern.

How many days per week do you eat: Breakfast-_______ Lunch-_______ Dinner-________

In a typical day, how many servings of breads, cereals, pasta or rice do you eat? _____________

Of the above, how many are whole grains? __________

In a typical day, how many servings of fruits do you eat? __________

Specify types of fruits: ____

In a typical day, how many servings of vegetables do you eat? __________

Of the above how many are dark green or bright orange vegetables? ___________

In a typical day, how many servings of beef, chicken and/or fish do you eat? __________

In a typical day, how many servings of meat alternatives do you eat (i.e.: tofu, soy burgers etc…)? __________

In a typical day how many servings of milk and dairy products do you eat? __________

Specify types of milk and dairy products: ____

In a typical day how many servings of nuts, legumes and/or beans do you eat? __________

Specify the types: ____

How often do you snack? Once Daily ( ) Twice Daily ( ) Three Times Daily ( )

When do you usually snack? ____

What are your typical snack foods? ____

____

Do you eat out? __________

What types of restaurants do you usually choose? _________________________________

Do you eat standing up? __________

Do you eat in the car? ___________

Do you eat at the table? ___________

Do you eat with others? __________

Do you engage in other activities when you eat? __________

Do you feel you eat fast? ___________

Who usually prepares the food at home? __________

Do you drink alcohol? If yes, the number and type of beverages per week: _________________

Who usually does the grocery shopping? __________

Do you read food labels? __________

If yes, what do you look for on food labels? ____

Is there any member of your household on a special diet? _______________________________

Do you take any vitamin, mineral or herbal supplements? __________

If yes, what type? ____

Do you have any food allergies? ___________

Specify: ____

____

What are your favorite foods? ____

____

Would you like to change your eating habits? __________

If yes, please explain why? ____

____

____

Do you exercise? If yes, what type, how often and for how long have you been exercising?

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***Please fax all completed nutrition forms directly to Patti Lindstrom's desk at 856.829.0398**