CARILLON SPORTS AND FAMILY MEDICINE

12225 28th Street N
St. Petersburg, FL, 33716
727-561-4303

Nutrition Questionnaire

Please take a few minutes to fill out this form to provide our Dietitian with a small window into your life. Carillon Sports and Family Medicine prides itself on personalized, proactive service. Thank you for your participation.

General Information

What is the reason for your visit today? What are your primary concerns?

_____

_____

What is your main goal for our discussion today?

_____

_____

What are your nutrition goals (check all that apply)?

☐ Weight Loss/Management
☐ Disease Prevention
☐ Sports/Athletics
☐ Diabetes
☐ Kidney Disease
☐ Food Allergies/Intolerances
☐ Child Nutrition
☐ Other _____

Have you seen a Registered Dietitian within the last 12 months for current reason or another?

☐ First Visit
☐ 2-5 Visits
☐ More than 6

Do you have any food allergies/intolerances?

☐ Yes | ☐ No

If yes, please list the foods that cause a problem: _____

_____

Do you take any supplements or over the counter medications?

☐ Yes | ☐ No

If yes, which ones? _____

Do you currently have, or within the last 6 months, any of the following symptoms (check all that apply)?

☐ Abdominal Cramping
☐ Arthritis
☐ Constipation and/or Diarrhea
☐ Skin rashes/Acne
☐ Asthma
☐ Dark circles under eyes
☐ ADD and hyperactivity
☐ Chronic mucus/stuffy nose
☐ Depression
☐ Psoriasis
☐ Congestion
☐ Eczema
☐ Fatigue
☐ Food cravings
☐ Gas and bloating
☐ Inability to lose weight
☐ Moodiness

Current Eating/Living Pattern

How often do you eat breakfast during the week?

☐ Every Morning
☐ 1-3 days
☐ Hardly Ever

How many meals do you usually eat per day?

☐ 1 meal or less
☐ 2-3 meals (no snacks)
☐ 2-3 meals + 1-2 snacks
☐ >4 meals

If 1 meal or less, why? _____

Please list at least 5 foods in each food group that you eat on a regular basis?

Dairy:

Meats/Protein:

Vegetables:

Fruits:

Nuts/Beans:

Please describe your work/home schedule (excessive travel, long hours, minimal break time, etc.?

_____

_____

How many hours per night do you usually sleep?

☐ less than 5 hours
☐ 5 – 7 hours
☐ > than 8 hours
Other _____

Please describe any additional stressors/environmental issues that may be affecting your diet/lifestyle?

_____

_____

How often do you exercise on a weekly basis?

☐ Never ☐ 1 – 3 days ☐ >4 days Other _____

Please describe which exercises you perform and how many minutes, if any:

_____

_____

How many glasses of water (8 ounces) do you drink daily?

☐ 1 glass or less ☐ 2-5 glasses ☐ 5-8 glasses ☐ >8 glasses

What other beverages do you like to drink? _____

_____

On a scale of 1 – 5, where 1 is not important and 5 is very important, how important is it for you to make changes related to your visit today?

Not important (1) ☐ (2)☐ (3)☐ (4)☐ (5)☐ Very Important

What motivates you? _____

Additional Information

Please share any additional comments, interests, and/or information that your Dietitian should know.

Thank you for taking the time to fill out this questionnaire. Your participation is greatly appreciated.