INE | INSTITUTE OF NUTRITIONAL ENDOCRINOLOGY

CHANGING LIVES WITH ROOT CAUSE HEALTH CARE

Dietary Habits Assessment

Current Habits and General Background

Have you made any changes in your eating habits because of your health? ❑ Yes ❑ No

Do you currently follow a special diet or nutritional program? ❑ Yes ❑ No
Check all that apply:

- ❑ Low fat
- ❑ Mixed food diet (animal and vegetable sources)
- ❑ High protein
- ❑ Vegetarian
- ❑ Vegan
- ❑ Gluten restricted
- ❑ Low sodium
- ❑ Fat restriction
- ❑ Low starch / carbohydrate
- ❑ The Blood Type Diet
- ❑ Metabolic Typing Diet
- ❑ The Zone Diet
- ❑ Total calorie restriction
- ❑ Ovo-lacto diet
- ❑ Paleo
- ❑ Diabetic
- ❑ No dairy
- ❑ No wheat
- ❑ Specific program for weight loss / maintenance
  Type:
  _____
  _____
  _____

Please check any specific food restrictions you have:

- ❑ Dairy
- ❑ Soy
- ❑ Wheat
- ❑ Corn
- ❑ Eggs
- ❑ All gluten
- ❑ Other:
  _____
  _____
  _____

List any special food equipment to which you have access:

Is there anything special about your diet that I should know?

Height (feet/inches) _____ Current Weight _____
Usual weight range +/- 5 lbs _____
Desired Weight range +/- 5 lbs _____
Highest adult weight _____ Lowest adult weight _____
Weight fluctuations (>10lbs) ❑ Yes ❑ No Body Fat % _____
How often do you weigh yourself? ❑ Daily ❑ Weekly ❑ Monthly ❑ Rarely ❑ Never

Do you grocery shop? ❑ Yes ❑ No
If no, who does the shopping? _____

When you shop do you purchase the following?
Organic foods ❑ Yes ❑ No
Hormone-free and antibiotic free meat ❑ Yes ❑ No

Do you read food labels? ❑ Yes ❑ No
Do you cook? ❑ Yes ❑ No
If no, who does the cooking? _____

How many meals do you eat out per week? ❑ 0-1 ❑ 1-3 ❑ 3-5 ❑ >5

Check all the factors that apply to your current lifestyle and eating habits:

- ❑ Fast eater
- ❑ Erratic eating habits
- ❑ Eat too much
- ❑ Late night eater
- ❑ Dislike health food
- ❑ Time constraints
- ❑ Eat more than 50% of meals away from home
- ❑ Travel frequently
- ❑ Non-availability of healthy foods
- ❑ Do not plan meals or menus
- ❑ Reliance on convenience items
- ❑ Poor snack choices
- ❑ Significant other or family members don't like healthy foods
- ❑ Significant other or family members have special dietary needs of food preferences
- ❑ Love to eat
- ❑ Eat because I have to
- ❑ Have a negative relationship to food
- ❑ Struggle with eating issues
- ❑ Emotional eater (eat when sad, lonely, depressed, bored)
- ❑ Eat too much under stress
- ❑ Eat too little under stress
- ❑ Don't care to cook
- ❑ Eating in the middle of the night
- ❑ Confused about nutritional advise
- ❑ Diet often for weight control
- ❑ Eat a lot of casseroles

Food Diary

Place a check mark next to any of the foods/drinks that apply to your current diet.

Usual Breakfast	Usual Lunch	Usual Dinner
❑ None	❑ None	❑ None
❑ Bacon/Sausage	❑ Butter	❑ Beans (legumes)
❑ Bagel	❑ Coffee	❑ Brown rice
❑ Butter	❑ Eat in a cafeteria	❑ Butter
❑ Cereal	❑ Eat in restaurant	❑ Carrots
❑ Coffee	❑ Fish sandwich	❑ Coffee
❑ Donut	❑ Fried foods	❑ Fish
❑ Eggs	❑ Hamburger	❑ Green vegetables
❑ Fruit	❑ Hot dogs	❑ Juice
❑ Juice	❑ Juice	❑ Margarine
❑ Margarine	❑ Leftovers	❑ Milk
❑ Milk	❑ Lettuce	❑ Pasta
❑ Oat bran	❑ Margarine	❑ Potato
❑ Sugar	❑ Mayo	❑ Poultry
❑ Sweet roll	❑ Meat sandwich	❑ Red meat
❑ Sweetener	❑ Milk	❑ Salad
❑ Tea	❑ Pizza	❑ Salad dressing
❑ Toast	❑ Potato chips	❑ Soda
❑ Water	❑ Salad	❑ Sugar
❑ Wheat bran	❑ Salad dressing	❑ Sweetener
❑ Yogurt	❑ Soda	❑ Tea
❑ Oat meal	❑ Soup	❑ Vinegar
❑ Milk protein shake	❑ Sugar	❑ Water
❑ Slim Fast shake	❑ Sweetener	❑ White rice
❑ Carnation shake	❑ Tea	❑ Wild rice
❑ Soy protein	❑ Tomato	❑ Yellow vegetables
❑ Whey protein	❑ Vegetables	❑ Other: (List below)
❑ Rice protein	❑ Water	
❑ Other: (List below)	❑ Yogurt	
	❑ Slim Fast shake	
	❑ Carnation shake	
	❑ Protein shake	
	❑ Other: (List below)	

Check foods/drinks that you consume a minimum of 3 days or more each week.
(List continues on to the next page)

- ❑ Almonds
- ❑ Almond Butter
- ❑ Alcohol
- ❑ Apples
- ❑ Avocado
- ❑ Asparagus
- ❑ Bagels
- ❑ Barley
- ❑ Banana
- ❑ Burger King
- ❑ Bacon
- ❑ Bean, Lima
- ❑ Bread, White
- ❑ Bread, Wheat
- ❑ Bread, Rye
- ❑ Bagels
- ❑ Biscuits
- ❑ Bean, Pinto
- ❑ Bean, String
- ❑ Broccoli
- ❑ Brazil Nuts
- ❑ Brussels Sprouts
- ❑ Blueberries
- ❑ Butter
- ❑ Cabbage
- ❑ Cereal, _____
- ❑ Celery
- ❑ Cantaloupe
- ❑ Candy
- ❑ Chinese Food
- ❑ Cream Cheese
- ❑ Carrot
- ❑ Chicken
- ❑ Chili Pepper
- ❑ Cinnamon
- ❑ Clam
- ❑ Cloves
- ❑ Cocoa / Chocolate
- ❑ Carnation Drink
- ❑ Chewing Gum, Sweetened
- ❑ Chewing Gum, Sugar- Free
- ❑ Coconut
- ❑ Cod
- ❑ Coffee
- ❑ Corn
- ❑ Crab
- ❑ Cranberry
- ❑ Cashew
- ❑ Cheese
- ❑ Cucumber
- ❑ Deli Meats
- ❑ Desserts
- ❑ Deli Sandwich
- ❑ Eggplant
- ❑ Ensure Shake
- ❑ Flounder
- ❑ Fried Foods
- ❑ French Fries
- ❑ French Toast
- ❑ Garlic
- ❑ Ginger
- ❑ Grape
- ❑ Grits
- ❑ Greek Food
- ❑ Grapefruit
- ❑ Grape Nuts
- ❑ Haddock
- ❑ Ham
- ❑ Halibut
- ❑ Herring
- ❑ Hot Dogs, Pork
- ❑ Hot Dogs, Beef
- ❑ Hamburgers
- ❑ Hardies Food
- ❑ Honey
- ❑ Italian Food
- ❑ Ice Cream
- ❑ Indian Food
- ❑ Jack in the Box food
- ❑ Japanese Food
- ❑ Jelly
- ❑ Ketchup
- ❑ Lamb
- ❑ Lemon
- ❑ Lentil
- ❑ Lettuce
- ❑ Lime
- ❑ Lobster
- ❑ Mackerel
- ❑ Margarine
- ❑ McDonalds Food
- ❑ Millet
- ❑ Mung Bean
- ❑ Mushroom
- ❑ Mustard
- ❑ Milk, Cow
- ❑ Milk, Goat
- ❑ Milk, Rice
- ❑ Milk, Almond
- ❑ Milk, Soy

- ❑ Mexican Food
- ❑ Malt
- ❑ Nutmeg
- ❑ NutriSweet
- ❑ Oatmeal, Regular
- ❑ Oatmeal, Instant
- ❑ Olive
- ❑ Onion
- ❑ Orange Juice
- ❑ Oregano
- ❑ Oyster
- ❑ Orange
- ❑ Papaya
- ❑ Parsley
- ❑ PopTarts
- ❑ Peanuts
- ❑ Peanut Butter
- ❑ Peas
- ❑ Peach
- ❑ Pecan
- ❑ Pepper
- ❑ Pepper, Green
- ❑ Perch
- ❑ Pineapple
- ❑ Pancakes
- ❑ Protein Shakes, Soy
- ❑ Protein Shakes, Milk
- ❑ Protein Shakes, Whey
- ❑ Plum
- ❑ Pork
- ❑ Peanut
- ❑ Potato, Sweet
- ❑ Potato, White
- ❑ Pumpkin
- ❑ Quinoa
- ❑ Radish
- ❑ Rye
- ❑ Safflower
- ❑ Sage
- ❑ Salt
- ❑ Salmon
- ❑ Scallops
- ❑ Sausage
- ❑ Slim Fast
- ❑ Sweet & Low
- ❑ Sesame
- ❑ Shrimp
- ❑ Snapper
- ❑ Soft Drinks
- ❑ Sole
- ❑ Sour Cream
- ❑ Soybean
- ❑ Spinach
- ❑ Strawberry
- ❑ Sucralose
- ❑ Sugar
- ❑ Sunflower
- ❑ Salad Bar
- ❑ Sardines
- ❑ Squash
- ❑ Taco Bell Food
- ❑ Tea, Black
- ❑ Tea, Decaffeinated
- ❑ Thai Food
- ❑ Tomato
- ❑ Trout
- ❑ Tuna
- ❑ Turkey
- ❑ Tangerine
- ❑ Vinegar
- ❑ Walnut
- ❑ Waffles
- ❑ Whitefish
- ❑ Wheat
- ❑ Wendy's Food
- ❑ Yeast, Bakers
- ❑ Yeast, Brewers
- ❑ Yogurt
- ❑ Yam
- ❑ Zucchini

What snacks do you eat or drink between:

Breakfast & Lunch:

_____

Lunch & Dinner:

_____

After Dinner:

_____

How much of the following do you consume each day/week?

Item	Daily	Weekly	Favorite Type
Candy			
Cheese			
Chocolate			
Cups of caffeine containing coffee			
Cups of decaffeinated coffee or tea			
Cups of hot chocolate			
Cups of caffeine containing tea			
Diet sodas (12-ounce can/bottle)			
Sodas with caffeine (12-ounce can/bottle)			
Sodas without caffeine (12-ounce can/bottle)			
Energy drinks (12-ounce can/bottle)			
Ice cream			
Salty foods			
Slices of white bread (rolls/bagels)			

Water: Glasses or volume/day _____

Type: ❑ Tap ❑ Distilled ❑ Spring ❑ Well ❑ Reverse Osmosis

Foods and Symptoms

Are there any foods/supplements that you avoid because they give you symptoms?

❑ Yes ❑ No

If yes, please name the food and symptom e.g. wheat – gas and bloating

Food/Supplement	Symptom	Other Comments

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.? ❑ Yes ❑ No

If yes, please explain:

_____

_____

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?

❑ Yes ❑ No

If you could only eat a few foods a week, what would they be?

_____

_____

_____

Do you feel worse when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Hot foods
- ❑ Cold foods
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other _____

Do you feel better when you eat a lot of:

- ❑ High fat foods
- ❑ High protein foods
- ❑ High carbohydrate foods (breads, pasta, potatoes)
- ❑ Hot foods
- ❑ Cold foods
- ❑ Refined sugar (junk food)
- ❑ Fried foods
- ❑ 1 or 2 alcoholic drinks
- ❑ Other _____

Does skipping meals greatly affect your symptoms? ❑ Yes ❑ No

Has there ever been a food that you have craved or really “pigged out” on over a period of time? ❑ Yes ❑ No

If yes, what food(s)

_____

_____

_____

Do you have an aversion to certain foods? ❑ Yes ❑ No

If yes, what food(s)

_____

_____

_____

The most important thing I should change about my diet to improve my health is:

_____

_____

_____

Tobacco History

Are you currently using tobacco? ❑ Yes ❑ No
If yes, how many years? _____ Packs per day _____
If yes, what type? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum
Number of attempts to quit _____

Were you previously a smoker? ❑ Yes ❑ No
If yes, how many years? _____ Packs per day _____
If yes, what type? ❑ Cigarette ❑ Smokeless ❑ Cigar ❑ Pipe ❑ Patch/Gum

Are you exposed to 2nd hand smoke? ❑ Yes ❑ No
If yes, please explain
_____
_____

Alcohol Intake

How many drinks do you currently consume per week?
1 drink = 5 ounces wine / 12 oz. beer / 1.5 ounces spirits
❑ None ❑ 1-3 ❑ 4-6 ❑ 7-10 ❑ >10

If you don't currently consume alcohol, did you consume alcohol more regularly in the past?
❑ Yes ❑ No **(If "No" skip to "Other Substances")**
Was your alcohol intake: ❑ Mild ❑ Moderate ❑ High

Have you ever been told to cut down your alcohol intake? ❑ Yes ❑ No
Do you get annoyed when people ask you about your drinking? ❑ Yes ❑ No
Do you ever feel guilty about your alcohol consumption? ❑ Yes ❑ No
Do you ever take an eye-opener? ❑ Yes ❑ No
Do you notice a tolerance to alcohol (can you "hold" more than others?) ❑ Yes ❑ No
Have you ever been unable to remember what you did during a drinking episode?
❑ Yes ❑ No
Do you get into arguments or physical fights when you have been drinking? ❑ Yes ❑ No
Have you ever been arrested or hospitalized because of drinking? ❑ Yes ❑ No
Have you ever thought about getting help to control or stop your drinking? ❑ Yes ❑ No
Was your mother an alcoholic? ❑ Yes ❑ No Father? ❑ Yes ❑ No
Other family member? ❑ Yes ❑ No

Other Substances

Are you currently using recreational drugs? ❑ Yes ❑ No
If yes, what types?

_____

_____

Have you ever used IV or inhaled recreational drugs? ❑ Yes ❑ No
If yes, what types?

_____

_____