

Elite Health & Fitness Training, Inc.
FOOD HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Height: _____ Weight: _____ Age: _____ Sex: _____

Weight History: _____

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:

Have you ever used laxatives for weight control? YES NO

Have you ever vomited for weight control? YES NO

Medical History: _____

Medications: _____

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?
