Food History Questionnaire and Assessment

It's recommended that you complete this form PRIOR to your first consultation with ELB. Your thoughtful responses will enable us to tailor your program more quickly, and help to get you on the fast track to a healthier life.

CONTACT INFORMATION

First Name: Last Name:

Occupation:

Address:

City: State: Zip:

Day Phone: Evening Phone:

Email: What is the best way to contact you?

WEIGHT LOSS HISTORY

1. Have you tried dieting before? Yes No

Diet 1: Weight Change: lbs. How long did it last?

Diet 2: Weight Change: lbs. How long did it last?

Diet 3: Weight Change: lbs. How long did it last?

2. Have you ever taken laxatives as a method of weight control? Yes No

3. Have you ever vomited as method of weight control? Yes No

4. Please provide a brief history of your weight gain and weight loss:

5. If you have ever been advised by your physician to follow a special diet (low salt, low fat, low cholesterol, no sugar, etc.), Please describe (include any changes you made at that time):

YOUR EATING PATTERNS

6. How many days a week do you eat... Breakfast? Lunch? Dinner?

7. How many times per day do you snack? Never Once Twice Three or more

8. When do you usually snack (check all that apply) Mid-morning Afternoon Evening Late-Night

9. What types of foods do you snack on?

10. How often do you eat out? Never Once or twice a month Weekly 2 or more times weekly

11. Which restaurants do you choose?

12. What do you typically order

YOUR EATING PATTERNS (CONTINUED)

Please choose the most appropriate response at the right for each of the following questions.	FREQUENTLY	OCCASIONALLY	RARELY	NEVER
13. Do you eat standing up?				
14. Do you eat in the car?				
15. Do you eat at the table?				
16. Do you eat with others?				
17. Do you set the table?				
18. Do you engage in other activities while you eat?				
19. Do you feel you eat fast / quickly?				
20. Do you engage in conversation while you eat?				
21 Do you prepare your own meals?				

22. On average, how many alcoholic beverages do you drink per week?

23. Who usually does the grocery shopping in your household?

24. Do you read nutrition labels? Usually Rarely

25. What do you look for on nutrition labels?

26. Besides yourself, please list all the other members of your household

First Name	Sex		Age
	M	F	
	M	F	
	M	F	
	M	F	
	M	F	
	M	F	

27. If any member of your household is on a special or restricted diet, please describe the circumstances:

28. Please describe any food allergies from you suffer:

29. What are your favorite foods?

30. Why are you interested in changing your eating habits?

PERSONAL STATS

Gender: Male Female

Birthdate: _____

Height: _____ft. _____in.

Weight: _____ lbs.

In the box below, please list current medical diagnosis such as HCL, obesity, diabetes, high blood pressure, etc.

List medications you currently take, including prescription and OTC:

List any any vitamin, mineral or food supplements you currently take.

Date: _____

Submit

Reset