ILLINOIS
McKinley Health Center

place label here

Name:
UIN:
Date:

Nutrition Information Questionnaire

Age: _____ ☐ Male ☐ Female
Year in School: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Grad

What nutrition information would you like to learn today? Please specify:_____

What changes are you willing to make to your meal plan in order to improve your health?
Please specify:
☐ Eat more fruits and vegetables ☐ Eat less fat ☐ Balance calories with activity
☐ Eat more whole grains ☐ Read nutrition labels ☐ None of the above

Do you have any health, medical or injury problems? Please specify:_____

Are you currently on any special diet (such as vegetarian, low fat, low calorie, low sodium)?_____

What medications/vitamin/mineral or other supplements do you take regularly?_____

Have you consulted a dietitian/nutritionist in the past? ☐ Yes ☐ No
If so, why?_____

What is your current height? _____ Weight _____ Goal Weight _____

Have you had any recent weight change?

☐ Yes ☐ No ☐ Increase – Amount _____ ☐ Decrease – Amount _____

Where do you eat most of your meals? (Check no more than two boxes):
☐ Apartment/House ☐ Fast Food Restaurants, (Specify) _____
☐ Sorority/Fraternity ☐ Other Restaurants (Specify) _____
☐ Residence Hall ☐ Other (Please specify) _____

Which meals/snacks do you usually eat?
☐ Breakfast ☐ Snack ☐ Lunch ☐ Snack ☐ Dinner ☐ Snack
What is your favorite snack food? _____

How many times per week do you exercise? _____ How many minutes each time? _____

List any physical activities that you do:_____

Do you smoke cigarettes? ☐ Yes ☐ No
Do you drink alcohol? ☐ Yes ☐ No
If yes, how much and how often?:_____

Please indicate which best describes you:
☐ I experience much stress and often feel unable to cope with it.
☐ I experience much stress and feel I am usually able to cope with it.
☐ I experience average or low-levels of stress and cope with it well.

(Please see the reverse side)

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Nutrition Information Questionnaire – page 2

Please write down what you eat on a normal day.

Meals/Snacks	Food	Amount Consumed	Beverage	Amount Consumed
Breakfast (Time)				
Snack/Dessert (Time)				
Lunch (Time)				
Snack/Dessert (Time)				
Dinner (Time)				
Snack/Dessert (Time)				

Please list any other food/beverage that you consume often:_____

_____

_____

_____

Reviewed by_____**Date**_____