HENDRICKS® FOR HEALTH
THE CENTER FOR WEIGHT MANAGEMENT

PERSONAL BEHAVIOR & EATING QUESTIONNAIRE

Patient Name____________________________________ **Date**_________________________

Please complete this form so we can review and discuss at either your office visit or scheduled Nutrition Consult.

Your answers to this questionnaire will help us understand your specific needs to better formulate an eating plan for weight loss, a healthy attitude about food, and a long-term eating style. Please answer as completely and as honestly as you can. This information will become a part of your confidential medical record. If there are any questions you prefer to discuss privately, write down "Discuss" and we can approach them in conversation.

BEHAVIORS:

1. When you are under stress or feeling down - do you eat ☐ more or ☐ less than usual? If more, what do you typically eat?

2. Is there a time of day when you eat more, have more cravings or lose control of your normal eating? ☐ Yes ☐ No If so, what time and describe:

3. What foods do you eat, or things you do, that are beneficial for your weight and health?

4. What foods do you eat, or things that you do, which may be a problem for your weight or for your health?

5. Have you ever had any formal nutritional training? ☐ Yes ☐ No If yes, describe:

6. Binge-eating means eating a greater quantity of food in a given amount of time than you think is normal. Do you ever binge eat? ☐ Yes ☐ No If yes, when was last binge?

7. Are you ever depressed? ☐ Yes ☐ No. If yes, do you take medications? ☐ Yes ☐ No

   - When you are depressed, do you ☐eat more or ☐ less than you normally do?
   - How often does this happen? ☐ most days ☐ once weekly ☐ once monthly

8. Are you or have you ever been a bulimic? ☐ Yes ☐ No

9. Have you had a binge-eating disorder in the past? ☐ Yes ☐ No

10. Are you or have you ever been an anorexic? ☐ Yes ☐ No

11. Some people seldom stop to eat a meal but continually nibble throughout the day. This is called grazing. Do you sometimes graze? ☐ Yes ☐ No If yes, describe.

12. Do you or have you ever taken over-the-counter medications or supplements that affect the way you eat or you weight? (suppositories, teas, herbs, weight loss pills, etc.)
☐ Yes ☐ No. If yes, list them:

FOODS AND MEALS:

1. Do you skip any meals? ☐ Yes ☐ No Which meal(s)?

2. Are you a nighttime eater? ☐ Yes ☐ No If yes, what is your pattern?

3. Do you drink water every day? ☐ Yes ☐ No How much?

4. Do you drink alcohol? ☐ Yes ☐ No If yes, what and how often?

5. Name three favorite go-to restaurants and what you eat at each one.

6. List three of your favorite foods you like to eat.

7. List three foods you dislike or will not eat.

8. Briefly describe a daily meal for breakfast, lunch dinner and any snacks.