HENDRICKS FOR HEALTH
THE CENTER FOR WEIGHT MANAGEMENT

Please complete and email to Paula, the Nutritionist, at:
Paula@hendricksforhealth.com
before your nutrition consultation.

PERSONAL BEHAVIOR & EATING QUESTIONNAIRE

Patient Name_____ **Date**_____

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 feel uncomfortable answering on paper, please write down "Discuss" and we can approach them in conversation.

BEHAVIORS:

1. When considering your daily food intake, do you eat:
   □ normal amounts □ more than normal amounts □ less than normal amounts
   Describe:

2. Do you skip meals? □ Yes □ No If so, which ones:

3. Do you sit down for meals? □ Yes □ No Where do you eat in your home?

4. Everyone has some kind of stress in their lives. When you are under stress - do you eat □ more or □ less than usual? If more, what do you typically eat?

5. 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:

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

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

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

9. Do certain things you eat have a tendency to trigger more eating or trigger cravings that create a problem? □ Yes □ No If so, describe:

10. 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:

    a. When was the last time you had a binge?

    b. How often do you binge?

    c. Have you had a binge-eating disorder in the past? □ Yes □ No

11. People who binge-eat often feel out of control while binging and then have remorse afterwards. Do you feel like this sometimes? □ Yes □ No If yes, explain:

12. Are you ever depressed? □ Yes □ No. If yes:

    a. When you are depressed do you □eat more or □ less than you normally do?

    b. If you eat more, what do you eat?

    c. How often does this happen? □ most days □ once weekly □ once monthly

13. Are you or have you ever been a bulimic? □ Yes □ No

14. Are you or have you ever been an anorexic? □ Yes □ No

15. Some people seldom really stop to eat a meal but continually nibble throughout the day. Sometimes people will eat meals and sometimes not. This is called grazing. Do you sometimes graze? □ Yes □ No If yes, describe.

16. 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 eat breakfast most days? □ Yes □ No

2. Do you have dessert after dinner most days? □ Yes □ No
   If yes, what do you have?

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

4. Are you a snacker or grazer? □ Yes □ No If yes, what is your pattern?

5. Do you drink alcohol? □ Yes □ No If yes, what is your pattern?

6. Name three favorite restaurants and what you eat at each one.

7. Name your three favorite fast food establishments and what you eat at each one.

8. List 3 of your favorite food choices you like to eat and in the order you prefer them with your favorite first.

9. List 3 foods you dislike or will not eat and in order with something you hate first.

10. Do you take vitamins or supplements? □ Yes □ No Write down a list or have them available to review at your scheduled Hendricks Method Book Review and Nutrition Consult.

Give us an example of what your meals consist of for a day.

Time OF DAY	*What's On Your Plate?*
	Breakfast
	Snack
	Lunch
	Snack
	Dinner
	Snack