ADULT Health Screening Questionnaire

Ages 18 and older

Date: _____ Clinician: _____

Name: _____ Birth date: _____

Please answer the following questions to help our providers learn more about your nutrition and physical health.

Do you skip breakfast, lunch or dinner?	Yes / No
Do you ever eat to the point where you feel uncomfortable or out of control?	Yes / No
(CIRCLE THOSE THAT APPLY) Do you have a history of, or are currently struggling with, an eating disorder, binge eating or emotional eating?	Yes / No
Do you have trouble sleeping?	Yes / No
Do you drink more than two servings of caffeine daily?	Yes / No
Do you have pre-diabetes or diabetes?	Yes / No
Do you have high cholesterol, high triglycerides or take medication for lowering cholesterol?	Yes / No
Do you have high blood pressure or take medication to lower blood pressure?	Yes / No
Have you lost or gained more than 10 pounds in the last 6 months? **(IF YES, CIRCLE ONE)**	Yes / No
Have you experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	Yes / No
During a normal week, how often are you physically active? _____ minutes per day _____ days per week	
On a scale of 1-10, how ready are you to be more physically active? _____ *(10=extremely motivated; 1= no motivation at all)*	
(CIRCLE THOSE THAT APPLY) Do you have any problems with swallowing, chewing, diarrhea, or constipation?	Yes / No
Do you follow any special diet? If yes, what type of diet? _____	Yes / No
Do you have any food allergies/intolerances/sensitivities? If yes, what foods? _____	Yes / No
Do you experience significant pain on a regular basis? *Examples: migraines, Fibromyalgia, Irritable Bowel Syndrome, etc.*	Yes / No
Do you have enough food to eat?	Yes / No
During a normal meal, is half the food on your plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to eat more fruits and vegetables? _____ *(10=extremely motivated; 1=no motivation at all)*	
Do you eat protein with every meal?	Yes / No
Do you drink 8 or more glasses of water a day?	Yes / No
What concerns, if any, do you have with your eating habits? _____ _____	
Do you smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are you to quit smoking cigarettes? _____ *(10=extremely motivated; 1=no motivation at all)*	
Would you like to schedule an appointment with the Dietitian? *If you answer YES to this question, a Registration staff member will contact you to schedule for nutrition services.*	Yes / No

An initial nutrition assessment is recommended to compliment the care you are already receiving here at Nystrom and Associates. Please discuss this with the Front Office Associate after your initial appointment or call (651) 529-8671 to speak with our Registration team.