

Patient Assessment Questionnaire for Nutrition Education

Name:			
What two main food or eating questions do you want answered today?			
1.			
2.			
What have you been told about food/eating and diabetes?			
Please tell us what you eat in a typical day:			Time
Breakfast or first meal			
Snack			
Lunch or second meal			
Snack			
Evening or third meal			
Snack			
How would you describe your appetite?	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Who prepares meals in your home?			
How many meals do you eat away from home each week?			
What food planning method do you use?			
<input type="checkbox"/> None	<input type="checkbox"/> Carbohydrate Counting	<input type="checkbox"/> Exchange lists	<input type="checkbox"/> Calorie Counting
			<input type="checkbox"/> Healthy Eating using the Food Pyramid
How much of the time are you able to follow it?			
<input type="checkbox"/> 0% - 25%	<input type="checkbox"/> 25% - 50%	<input type="checkbox"/> 50% - 75%	<input type="checkbox"/> 75% - 100%
Has your weight changed in the last year? <input type="checkbox"/> No <input type="checkbox"/> Gained <input type="checkbox"/> Lost			
What do you think is a realistic weight for you?			
Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, what:		How many per week?	
Do you take vitamins or herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list:			
Do you exercise now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
What do you do?			
If you do not exercise now, what activities would you consider?			

Source: Reprinted with permission from: Franz MJ, Reader D, Monk A. *Implementing Group and Individual Medical Nutrition Therapy for Diabetes*. Alexandria, VA: American Diabetes Association; 2002: 59.