

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.