



Optimum Health Wellness Center, Inc.

Nutrition Questionnaire

Name: _____ Date _____

This form is designed to evaluate your nutritional status and to understand your dietary desires and patterns. Please answer all questions as completely as possible.

How many glasses of water do you drink per day? _____ Type of water _____

How often do you skip meals (deviate from 3 meals daily)? _____

Do you use butter or margarine? _____

What type of salad dressing do you usually use? _____

When you eat bread is it white, whole wheat, or some other type of grain? _____

Do you often feel hungry regardless of how much you eat? _____

Do you crave carbohydrates (baked, or pastas), sweets, or salt? _____

What type of snack foods do you usually eat? _____

List your 5 favorite foods _____

Do you seem to gain weight easily? _____

Do you have difficulty losing weight? _____

How often do you eat fried foods? _____/day, _____/week, _____/month

How often do you eat fast foods? _____/day, _____/week, _____/month

Do you usually go back for 2nd, 3rd, or more portions at meal time? _____

What time do you usually eat your last meal of the day? _____

How often do you eat canned foods? _____/day, _____/week, _____/month

Approximately how often do you exercise? _____/week, _____/month

Do you get tired and sleepy or feel ill after eating certain foods? _____ Explain: _____