CLIENT INTERVIEW QUESTIONNAIRE

The Nutrition Twins®
Tammy Lakatos Shames, RD, LD, CDN, CFT and Lyssie Lakatos, RD, LD, CDN, CFT

Name_____ **Phone (_____)**_____

Age_____ **Date** _____

Height_____

Weight_____

Profession_____

What is your main reason for this consultation? (Please circle): Weight Loss/ Increase Energy/ Better Health/ Sports Enhancement/ Disease Prevention/ Weight Gain/ Hypertension/ High Cholesterol
Other_____

Please list any medical diagnoses (i.e. High Blood Pressure, Osteoporosis, IBS, etc.)
_____
_____

Please list any current or past medical problems
_____
_____

Please list any food allergies_____

Females only:
Are your menstrual cycles normal?_____
Have your menstrual cycles ever been irregular?_____

Please list any medications you are taking on a regular basis, (including birth control pills)
_____

List food and /or vitamin supplements you are taking: (including herbs, sports drinks, etc., please list type and dose)_____
_____

Is there any history of family medical problems? (i.e. immediate members of family have heart disease, high cholesterol, cancer, etc.) If so, please describe._____
_____
_____

Please list any psychological diagnoses (type of eating disorder, depression, etc.)
_____
_____

Marital status_____ **Children and ages**_____

Current living situation (who does the cooking?)_____

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Current work situation (refrigerator, microwave available?)_____

Have you ever worked with a dietitian? _____

What was your highest weight?_____ **Age**_____
Lowest weight?_____ **Age**_____

How often do you weigh yourself?_____

What weight do you feel most comfortable at?_____

Last time you weight this, and for how long?_____

Are any members of your family struggling with weight issues?
_____

If the answer to the last question is yes, has this influenced your eating behavior in any way?_____

Are you currently exercising? If yes, please list amount and types of exercise (including cardiovascular and strength training exercises). Be as specific as possible. List number of days/ week and time spent doing each activity. Also, try to give speeds of machines or intensity levels to help us to determine how many calories that you burn on a weekly basis from exercise.

What do you consider to be your problem areas? (Please Circle): Craving sweets/ Craving Salts/ Bingeing late at night/ Bingeing late in the afternoon/ Stress Eating/ Boredom Eating/ Other, Please specify
_____

Do you often skip meals?_____

Do you usually eat when you are hungry?_____

Do you often eat when you are not hungry?_____

Please list the foods that you like the most._____
_____

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Please list some of the foods that you dislike the most._____
_____

Are you a vegetarian?_____

Please list any foods that you have eliminated from your diet._____
_____

How much water do you drink daily? _____

How many sodas do you drink daily?_____

How many alcoholic drinks do you have daily or weekly? (Please be specific about kind of alcohol and size of drink).
_____
_____

Please circle the foods that you like and cross out the ones that you don't like. Place an N next to the ones that you feel neutral about. Put a question mark next to the foods that you are unsure about.

CARBOHYDRATES

GRAINS: whole wheat breads, white bread, bagels, oatmeal, brown rice, white rice, pasta, whole wheat pasta, pretzels, popcorn (air popped), All Bran Cereal, Shredded wheat, Cheerios, pancakes, waffles, Raisin Bran, Corn Flakes,
Please specify other grains and cereals that you do and don't like_____

FRUITS: cantaloupe, honeydew, strawberries, bananas, apples, oranges, grapefruit, applesauce (no sugar added), peaches, plums, nectarines, watermelon, raisins, blueberries, kiwi, mango, grapes, pineapple, pears, orange juice
Please specify other fruits that you do and don't like_____
_____

VEGETABLES: corn, peas, potatoes, sweet potatoes, spinach, kale, carrots, lettuce: romaine, red leaf, iceberg bell peppers: red, green, yellow broccoli, cauliflower, brussel sprouts, cabbage, asparagus, squash, artichokes, baby carrots, mushrooms, celery, cucumber, beets, tomatoes, olives, snow peas, green beans, onions
Please specify other vegetables that you do and don't like_____
_____

PROTEINS

DAIRY: milk: 1%, skim, lactose reduced, soy milk, rice milk, yogurt: plain low-fat non-fat, yogurt fruit flavored (<u>light,</u> non-fat), fruit flavored fat-free or

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low-fat yogurt, low-fat cheese, nonfat cheese, cheese sticks, soy cheese, cottage cheese: nonfat, 1%, 2%, parmesan cheese, sour cream: low-fat, non-fat
Please specify other dairy products that you do and don't like_____
_____

MEAT GROUP: skinless chicken breast, skinless turkey breast, red meat: ground chuck or round, pork loin, Canadian bacon, fish: salmon, tuna (fresh, canned), trout, red snapper, grouper, shrimp, crab, sushi rolls, tofu, veggie burgers, turkey dogs, soy dogs, peanuts, cashews, almonds, beans: pinto, red, black, refried, chick peas, hummus,
Please specify other foods in the meat group that you do and don't like_____
_____

OTHERS

Nutrasweet, Equal, Low-fat baked chips, Non-fat frozen yogurt/ ice cream, Low-fat frozen yogurt/ ice-cream, hot chocolate (water based, milk based), peppermint patties, sugar-free fudge popsicles/ juice pops, 100% fruit juice popsicles, soda, diet soda, fruit juice, vegetable juice, Crystal light, decaf tea, decaf coffee, coffee, jelly: low sugar cream cheese: non-fat, low-fat, mayonnaise: non-fat, light, reduced-fat, butter buds, butter spray, butter, light butter, tub spreads, margarine, ketchup, mustard, cooking spray, canola oil, olive oil, salad dressing: light, non-fat, reduced calorie

How many times per week do you eat out (all meals included)? Fast food _____
Other restaurants_____

What types of places do you eat out at most often, and what do you usually get? Please mention condiments you use, like salad dressing, mayonnaise, mustard, butter, etc.

Fast food restaurant:_____ **Your typical choices**_____

Fast food restaurant:_____ **Your typical choices**_____

Fast food restaurant:_____ **Your typical choices**_____

Fast food restaurant:_____ **Your typical choices**_____

Other restaurant:_____ **Your typical choices**_____

Other restaurant:_____ **Your typical choices**_____

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Other restaurant:_____ **Your typical choices**_____

Have you read any books about food, nutrition, or weight loss? If so, describe?_____
_____

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What would you like to learn about in our sessions?_____
_____

Please include other information that would be helpful for me to know._____
_____

We want to try to incorporate small dietary changes into your current lifestyle. Therefore, we need to know what a typical day is like for you. Try to write what time you wake up and what you usually eat throughout the day and the times that you eat. Also, mention where you are when you eat- work, car, home, etc. Also be as specific as you can. Don't forget to include the condiments that you use.

Here is an example of the information that we are looking for:

7:00 wake, walk dog
7:30 eat breakfast at home coffee, 2 tablespoons cream, 1 plain Lender's bagel, 1 tablespoon light cream cheese
8:00 go to work
10:00 snack 8 oz. Colombo light yogurt, 8 ounces water, peach
12 ish eat lunch at work from Subway. 12 ounce coke, 6" sub with turkey, mayonnaise, lettuce and tomato, small bag baked lays, etc. etc,,,,,

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Food Diary

Please complete all categories so that we can be as helpful as possible.

DAY, TIME, ACTIVITY	**FOOD** (include condiments, butter, dressings, drinks, supplements)	**DESCRIPTION** (brand name, preparation method, low fat, etc.)	**SERVING SIZE** (Tbsp., cup ounce, etc.)
Ex: Monday, 7:00am, walk dog, 7:30 deli	Ex: bagel Ex: cream cheese	Ex: H & H brand plain bagel Ex: low fat cream cheese	Ex: the size of my hand, fingers spread, 6 ounces? Ex: 1 ounce