Fitness That Works, Inc.

Dietary Questionnaire

Name_____ Age_____

Height_____ Weight_____

1. Do you eat at regular times each day? *Yes* *No*

2. How many days a week do you eat..

a morning meal?_____ a lunch or midday meal?_____

an evening meal?_____ a meal during the night?_____

3. How many days a week do you have snacks.

in the midmorning?____ in the mid-afternoon?_____

in the evening?_____ during the night?_____

4. Which meals do you usually eat with your family? *None* *Breakfast* *Lunch* *Dinner*

5. How many times per week do you eat meals in a cafeteria or restaurant?

Breakfast_____ Lunch_____

Dinner_____ Snacks_____

6. Would you describe you appetite as: *Good* *Fair* *Poor*

7. At what time of the day are you most Hungry *Morning* *Noon* *Evening*

8. What foods do you dislike?

_____

9. Are you on a special diet now? *Yes* *No*

If yes, why are you on a diet (circle one)

Weight Reduction (Doctor's Prescription) *Gaining Weight*

Allergy (specify) *Other reason (specify)*

If no, have you been on a special diet within the past year? *Yes* *No*

If yes, for what reason (specify) _____

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10 How many times per week to you eat the following foods (at any meal or between meals)? Please number 0-7 or greater.

Bacon_____ Sausage_____ Luncheon Meat_____ Hot Dogs

Liver_____ Poultry_____ Pork or Ham_____ Beef or Veal_____

Other Meat_____ Fish_____

Meat in mixtures (stew, casseroles, tamales, etc.

11. How many times per week do you eat the following foods (at any meal or between meals)? Please number 0-7 or greater.

Fruit Juice_____ Fruit_____

Cereal-Dry_____ Cereal-Cooked or instant_____

Eggs_____ Pancakes or waffles_____

Cheese_____ Potato_____

Other cooked vegetables_____ Raw Vegetable_____

Ice Cream, milk, pudding, custard, or cream soup_____

Macaroni, Spaghetti, Rice, Noodles_____ Dried beans or peas_____

Peanut Butter or Nuts_____ Crackers or Pretzels_____

Sweet Rolls or doughnuts_____ Pie, Cake or Brownies_____

Cookies_____ Candy_____

Potato Chips or Corn Chips_____ Soft Drinks, popsicles or kool-aid_____

Instant Breakfast_____ Alcoholic Beverages_____

12. How many servings per day do you eat the following foods? Please number 0-7 or greater

Bread, toast, rolls, muffins (1 slice or piece = serving)_____

Milk (including on cereal or other foods (8 oz. = serving_____

Sugar, jam, jelly, syrup (1 teaspoon = serving)_____

13. What specific kinds of the following foods do you eat most often?

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Frui uices Fruit _____

'egetables_____ Cheese_____

Cooked or Cerea Dry Cereal

Milk_____

What your past medical history

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_____ _____ _____ _____

What your medical history

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Do have health probl h taking ption medications that the presen

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