The Goldring Center for Culinary Medicine

TULANE UNIVERSITY

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Nutrition Screening Form

On a scale of 1-5, please indicate to what degree you agree with each of the following statements:
(1 = strongly disagree, 2 = somewhat disagree, 3 = neutral or N/A, 4 = somewhat agree, 5 = strongly agree)

I am not satisfied with my current weight and body shape.	
I worry about gaining weight.	
I frequently experience dizziness, extreme fatigue, or lack of stamina.	
I watch what I eat very carefully to avoid gaining weight.	
I worry sometimes that I will run out of food and won't have enough money to buy more.	

How often do you eat or drink each of the following or do the following:

	Daily	A few times per week	A few times per month	Rarely/ Never
Fruit				
Vegetables				
Whole grains				
Sports drinks (Gatorade, etc.)				
Soda, juice, sweet tea, or other sweetened beverages				
Meals from restaurants or fast food				
Meals prepared at home				
Protein bars, protein shakes, or supplements in place of meals				
Skip meals				
Eat while watching TV, working on the computer, studying				

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Please answer the following questions:

Have you had any recent changes in your appetite? _____

If yes, has it increased or decreased? _____

Have you had any recent changes in your weight? _____

If yes, how much weight have you lost or gained? _____

Do you have regular bowel movements? _____

If not, how often do you have a bowel movement? _____

Do you follow a particular diet (ex: Paleo, vegan, etc.)? _____

If yes, what diet do you follow? _____

Do you have any dietary restrictions? _____

If yes, what restrictions do you have? _____

Do you take any dietary supplements? _____

If yes, what do you take? _____

How much water do you drink per day? _____

Who purchases and prepares food when you eat at home? _____

Please describe your current exercise regimen. _____

_____

_____