

ACE NUTRITION QUESTIONNAIRE

Name: _____ Age: _____ Date: _____

Have you been following any special diets at the current time? (low-fat, vegetarian, low-calorie, low-carb, diabetic, allergy, Weight Watchers, etc.) _____

What would you like to learn about nutrition while under our care or do you have any nutritional goals? _____

When and how do you think your eating issues began? _____

Height: _____ Weight: _____ Highest Weight: _____ When: _____

Lowest Weight: _____ When: _____ Comfortable Weight: _____

Have you been able to maintain “your comfortable weight” for any period of time?

Yes ____ No ____ If yes, how long? _____

How often do you weigh yourself? _____

When was your last physical? _____

Have you ever had any abnormal blood work results? Yes ____ No ____

If yes, please list abnormal tests: _____

Do you have any significant family medical history? Yes ____ No ____

If yes, please list here: _____

Check any of the following medical/physical issues that currently apply to you:

Bloating/edema ____ Constipation ____ Diarrhea ____ Reflux ____

Gas ____ Insomnia ____ Fatigue ____ Low energy levels ____

Headaches ____ Light headedness ____ Bruise easily ____ Muscle Cramps ____

Hypoglycemia (low blood sugar) ____ Diabetes (high blood sugar) ____

Hair Loss ____ Dental Problems ____ Cold sensitivity ____ Insulin resistance ____

High Blood pressure ____ Other: _____

Please list any other medical or psychiatric issues or diagnoses that may have nutritional implications on your health: (immune problems, hormone, previous cancers, depression, anxiety, obsessive compulsive issues, other disease issues or gastrointestinal issues, etc.)

Females Only – Below for next 4 questions

Have you started menstruation? Yes_____ No_____

If yes, at what weight approximately did you start menstruating? _____lbs.

Are your menstrual cycles normal or regular? Yes_____ No_____

Have your menstrual cycles ever been irregular? Yes___ No___ Explain: _____

If your menstruation stopped, are you aware at what weight you lost your period? If yes, please list the weight you last menstruated at? _____

Do you currently take any nutritional supplements including vitamins, minerals, herbals (eg. ginseng, MaHuang, ginko) or food supplements (e.g. Ensure, Boost, weight gain powders)?

Yes_____No_____ If yes, please list types: _____

Do you take any medicines on a regular basis? Please list: _____

Have you ever or are you currently participating in the following behaviors?

Binging? Yes_____ No_____ Last Time: _____ How often: _____x/wk

Vomiting following food intake? Yes_____ No_____ Last Time: _____ How often: _____x/wk

Restricting calories? Yes_____ No_____ What calorie level do you adhere to? _____

Restricting/limiting certain foods/food groups? Yes_____ No_____

Which foods are you currently restricting? _____

Would you consider yourself an emotional eater? Yes_____ No_____

Do you currently use any diet, low-fat or fat-free foods or condiments (milk, frozen desserts, condiments – margarine, cream cheese, or salad dressing)? Yes_____No_____

If yes, please list here: _____

Do you have any other foods which you would consider fear foods or foods that you have completely eliminated out of your diet? _____

Are there any other foods that you limit because of allergies, religious reasons, or have never liked? Yes_____ No_____ If yes, describe what foods and reasons why: _____

Laxative (or enema) abuse? Yes_____ No_____ Last Use: _____
How many times per week? _____ What type? _____
Do you (Over-)exercise? Yes_____ No_____ Last time: _____ Type: _____
If you do regularly exercise, describe your workout routine: _____

Use of diet pills (or diuretics)? Yes_____ No_____ Last Use: _____ How often: _____x/wk
Parent's marital status: Single: _____ Married: _____ Divorced: _____ Widowed: _____
Your current living situation: With parents: _____ With spouse: _____ With a Friend(s): _____
With a roommate(s): _____ With sibling(s): _____

Who does most of the grocery shopping? _____

Who does most of the cooking? _____

Do you like to shop for groceries? _____

Do you like to cook? _____

Would you like to cook more? _____

How many times per week do you normally dine out? _____

What types of restaurants and what types of entrée choices do you normally make? _____

Do you struggle with shopping, cooking, or dining out? Yes_____No_____

Describe: _____

Do any members of your family have weight issues? (i.e. obesity, eating disorders)

Yes _____ No _____ If yes, who? _____

If yes, did this influence your eating in any way? _____

Does your family sit down for family meals? Yes _____ No _____

Have you ever seen a Dietitian or Nutritionist before? _____ How often? _____

Do you still see this person? _____. Name: _____

Phone Number of Dietitian/Nutritionist: _____

Would you give permission for us to contact your previous RD? Yes _____ No _____

Please provide any other information in the space below regarding your eating habits that you feel we should be made aware of in order to provide you with optimum nutritional care (e.g. any other food fears or rituals you would like to have addressed while you are here: _____

The above questionnaire was developed by
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