Nutrition Clinic Questionnaire	Patient Name: _____		Date of Visit: _____	
How many servings **per day** does the patient have of the following on MOST DAYS of the week: Circle the column that applies most of the time.				Additional Comments:
Fruits	0	1	2+	
Vegetables	0	1	2+	
100% Juice	0	1	2+	
Milk	0	1	2+	
Soda, punch, sports drinks	0	1	2+	
Sugar-free/ diet drinks	0	1	2+	
Water	0	1	2+	
How many times per week does the patient?				
Eat dinner with family	Rarely	Some Days	Most Days	
Eat fast food/ take out	Rarely	Some Days	Most Days	
Eat fried food	Rarely	Some Days	Most Days	
Eat breakfast	Rarely	Some Days	Most Days	
Eat lunch	Rarely	Some Days	Most Days	
Eat dinner	Rarely	Some Days	Most Days	
Have snacks	Rarely	Some Days	Most Days	
Skip a meal	Rarely	Some Days	Most Days	
How would the patient describe their typical portion size?	Too little	Just right	Too much	
During meals, how often does the patient eat fast?	Rarely	Sometimes	Most of the time	
During meals, how often does the patient have second helpings?	Rarely	Sometimes	Most of the time	
How much time does the patient spend each day on electronics outside of school/ work? (TV, phone, computer, tablet)	< 2 hours	2-4 hours	>4 hours	

How many minutes/ day is the patient physically active?	<30	30-60	>60	
How many days/ week is the patient physically active?	Rarely (0-1)	Some Days (2-3)	Most Days (4-7)	
Typically how much sleep does the patient get each night?	< 5 hours	5-7 hours	8+ hours	
How is the patient dealing with current stressors?	No concerns, doing well	Some concerns	Concerned	
Does stress impact your appetite or how much you eat?	Never/ Rarely	Sometimes	Most days	
Does the patient ever feel out of control when eating?	Never/ Rarely	Sometimes	Most days	