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# EMPOWER

## SURGICAL & MEDICAL WEIGHT LOSS

powered by  BinghamHealthcare

### New Patient

### Nutrition & Exercise Questionnaire

Welcome to our Program. In order to provide you exceptional care, we need to understand your current dietary and exercise habits.

Please complete this questionnaire to the best of your ability and bring it to your appointment with the medical provider.

We look forward to serving you! If you have any questions, don't hesitate to call our office:

208-782-3993



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<b>General Information:</b>	<p>Name: _____ (last) (first) (middle)</p> <p>Gender: Female      Male</p> <p>Age: _____      Date of Birth: _____</p> <p>Address: _____ (number, street)</p> <p>_____  (city, state, zip)</p> <p>Email: _____</p> <p>Phone: _____</p>
<b>Marital Status:</b>	<p><input type="checkbox"/> Single</p> <p><input type="checkbox"/> Married</p> <p><input type="checkbox"/> Divorced</p> <p><input type="checkbox"/> Widowed</p>



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<p><b>Home Environment:</b></p>	<p>List all people living in your home: _____          _____</p> <p>Number of children living at home: _____</p> <p>Please list the ages of your children at home: _____</p> <p>Who does the grocery shopping: _____</p> <p>Who performs the majority of the meal planning and cooking:          _____</p> <p>Do you have any religious or cultural influences to the meals that are consumed in your home:</p> <p><input type="checkbox"/> Yes Explain: _____</p> <p><input type="checkbox"/> No</p>
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Eating Environment:

<p>Where do you consume the majority of your meals?</p>	<p><input type="checkbox"/> In the kitchen, at a table</p> <p><input type="checkbox"/> On the couch, watching TV</p> <p><input type="checkbox"/> At the computer</p> <p><input type="checkbox"/> In the car</p> <p><input type="checkbox"/> Other, explain: _____</p>
<p>How many meals per week do you:</p>	<p><input type="checkbox"/> Eat at a fast food restaurant          ___ 1-2 ___ 3-4 ___ 5 or more</p> <p><input type="checkbox"/> Eat at a sit down restaurant          ___ 1-2 ___ 3-4</p> <p><input type="checkbox"/> Eat while driving          ___ 1-2 ___ 3-4</p>



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Eating Patterns:

How quickly do you normally eat?	<input type="checkbox"/> Quickly <input type="checkbox"/> Moderate pace <input type="checkbox"/> Slowly
Do you chew your food thoroughly?	<input type="checkbox"/> Yes <input type="checkbox"/> No Do you have dental issues that affect chewing?    Yes    No
What prompts you to eat? <small>(select all that apply to you)</small>	<input type="checkbox"/> Clock, eat at normal "meal times" <input type="checkbox"/> Physical hunger, I eat when I am hungry <input type="checkbox"/> Emotions (stress, boredom, lonely) <input type="checkbox"/> Entertainment (I like to eat out with family / friends) <input type="checkbox"/> Cravings, explain: _____ <input type="checkbox"/> Other, explain: _____
How do you decide the quantity of food you eat? <small>(select all that apply to you)</small>	<input type="checkbox"/> Eat until I am comfortably full <input type="checkbox"/> I eat until I am "stuffed" or uncomfortable <input type="checkbox"/> Size of the meal served, I always clean my plate <input type="checkbox"/> Package size, I have trouble stopping once I have started eating <input type="checkbox"/> Other, explain: _____

Food Intake:

How many meals do you eat daily?	<input type="checkbox"/> 1-2 <input type="checkbox"/> 2-3 <input type="checkbox"/> 3 or more
When do you snack? <small>(select all that apply to you)</small>	<input type="checkbox"/> I don't snack <input type="checkbox"/> Throughout the day, no set time <input type="checkbox"/> Between breakfast and lunch <input type="checkbox"/> Between lunch and dinner <input type="checkbox"/> After dinner <input type="checkbox"/> Late night
What do you snack on?	List top 5  1: _____ 4: _____ 2: _____ 5: _____ 3: _____



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<p>Do you skip any meals? (select all that apply to you)</p>	<input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Dinner
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**Allergies** are an immune response to food. A **Food Intolerance** is a lack of a digestive enzyme to breakdown certian foods in the gut.

<p>Do you have any food allergies?</p>	<input type="checkbox"/> Yes, explain: _____ <input type="checkbox"/> No
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<p>Do you have food intolerances?</p>	<input type="checkbox"/> Yes, explain: _____ <input type="checkbox"/> No
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<p>On average, how many days a week do you eat:</p>	<table> <tr> <td>Fruit: _____</td> <td>Pork: _____</td> </tr> <tr> <td>Vegetables: _____</td> <td>Bread: _____</td> </tr> <tr> <td>Red meat: _____</td> <td>Pasta: _____</td> </tr> <tr> <td>Fish: _____</td> <td>Rice: _____</td> </tr> <tr> <td>Chicken: _____</td> <td>Desserts: _____</td> </tr> </table>	Fruit: _____	Pork: _____	Vegetables: _____	Bread: _____	Red meat: _____	Pasta: _____	Fish: _____	Rice: _____	Chicken: _____	Desserts: _____
Fruit: _____	Pork: _____										
Vegetables: _____	Bread: _____										
Red meat: _____	Pasta: _____										
Fish: _____	Rice: _____										
Chicken: _____	Desserts: _____										

<p>List your top 5 favorite foods:</p>	<ol style="list-style-type: none"> <li>1. _____</li> <li>2. _____</li> <li>3. _____</li> <li>4. _____</li> <li>5. _____</li> </ol>
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<p>Do you use a food tracking app?</p>	<input type="checkbox"/> Yes, which one?: _____ <input type="checkbox"/> No
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**Beverage Intake:**

<p>How many ounces per day do you drink:</p>	<table> <tr> <td>Water: _____</td> <td>Coffee: _____</td> </tr> <tr> <td>Soda : _____</td> <td>Tea: _____</td> </tr> <tr> <td>Diet Soda: _____</td> <td>Juice: _____</td> </tr> <tr> <td>Energy drinks: _____</td> <td>Milk: _____</td> </tr> <tr> <td>Alcohol: _____</td> <td>Other: _____</td> </tr> <tr> <td>Low calorie drinks: _____</td> <td></td> </tr> </table>	Water: _____	Coffee: _____	Soda : _____	Tea: _____	Diet Soda: _____	Juice: _____	Energy drinks: _____	Milk: _____	Alcohol: _____	Other: _____	Low calorie drinks: _____	
Water: _____	Coffee: _____												
Soda : _____	Tea: _____												
Diet Soda: _____	Juice: _____												
Energy drinks: _____	Milk: _____												
Alcohol: _____	Other: _____												
Low calorie drinks: _____													



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Three Day Food Diary:

To the best of your ability, please record the foods and drinks you have consumed for the past three days. Please do not change what you normally eat so that we can have a good idea of what your typical diet consists of.

**Day 1:**

Date: \_\_\_\_\_

Meal	Items	Approximate Quantity Cups or Ounces	Hunger Level 3 = Starving 2 = Moderately hungry 1 = Not hungry
Breakfast			
Mid-morning Snack			
Lunch			
Mid-afternoon Snack			
Dinner			
Late-night Snack			

Notes: \_\_\_\_\_  
\_\_\_\_\_



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Day 2:

Date: \_\_\_\_\_

Meal	Items	Approximate Quantity Cups or Ounces	Hunger Level 3 = Starving 2 = Moderately hungry 1 = Not hungry
Breakfast			
Mid-morning Snack			
Lunch			
Mid-afternoon Snack			
Dinner			
Late-night Snack			

Notes: \_\_\_\_\_

\_\_\_\_\_



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Day 3:

Date: \_\_\_\_\_

Meal	Items	Approximate Quantity Cups or Ounces	Hunger Level 3 = Starving 2 = Moderately hungry 1 = Not hungry
Breakfast			
Mid-morning Snack			
Lunch			
Mid-afternoon Snack			
Dinner			
Late-night Snack			

Notes: \_\_\_\_\_

\_\_\_\_\_



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Do you consider yourself:	<input type="checkbox"/> Active <input type="checkbox"/> Semi-active <input type="checkbox"/> Inactive
What exercise methods have you tried in the past?	<input type="checkbox"/> Bicycling <input type="checkbox"/> Jogging <input type="checkbox"/> Walking <input type="checkbox"/> Swimming <input type="checkbox"/> Gym membership <input type="checkbox"/> Video tapes <input type="checkbox"/> Home gym equipment <input type="checkbox"/> Other _____
Are you currently exercising on a regular basis?	<input type="checkbox"/> No <input type="checkbox"/> Yes, if so what method _____
Do you walk for fitness and count your daily steps?	<input type="checkbox"/> No <input type="checkbox"/> Yes, what number of steps do you average on a daily basis? _____
Do you own a pedometer (step counter)?	<input type="checkbox"/> No <input type="checkbox"/> Yes
What prevents you from exercising on a regular basis?	<input type="checkbox"/> Pain, where? _____ <input type="checkbox"/> No access to equipment <input type="checkbox"/> Do not know how <input type="checkbox"/> Inability to walk