Behavioral Nutrition Assessment

Name:_____Date of Birth:_____ Age:_____

The Behavioral Nutrition Assessment will allow me to assess your overall relationship with food, eating behaviors and beliefs and about food and nutrition.

Eating Patterns, Behaviors & Attitudes Part 1: *Please check yes if you mostly agree with the following statements. Please check no if you mostly disagree with the following statements. We will review this assessment together during your first appointment and I will ask follow-up questions about your answers to obtain more detailed information about frequency of eating behaviors/thoughts etc.*

I eat when I am bored	□ Yes □ No	I eat while I am on the computer	□ Yes □ No	I eat standing up	□ Yes □ No
I eat when I am stressed	□ Yes □ No	I enjoy eating with others	□ Yes □ No	I eat in the car	□ Yes □ No
I eat when I am lonely	□ Yes □ No	I eat faster than others	□ Yes □ No	I read food labels	□ Yes □ No
I eat when I am sad	□ Yes □ No	I eat slower than others	□ Yes □ No	I count calories	□ Yes □ No
I eat when I am anxious	□ Yes □ No	I eat while watching TV	□ Yes □ No	I count fat grams	□ Yes □ No
I usually eat 3 meals/day	□ Yes □ No	I often eat more than others	□ Yes □ No	I count protein grams	□ Yes □ No
I usually 1-3 snacks/day	□ Yes □ No	I often eat less than others	□ Yes □ No	I count carb grams	□ Yes □ No
I "graze" most of the day	□ Yes □ No	I often eat when I am not hungry	□ Yes □ No	I weigh/measure food	□ Yes □ No
I overeat at least 1x day	□ Yes □ No	I eat when I feel physical hunger	□ Yes □ No	I often crave foods	□ Yes □ No

Can you tell the difference between emotional hunger and physical hunger? □ Yes □ No
Can you tell the difference between emotional fullness and physical fullness? □ Yes □ No
What most often triggers you to start eating? (Check all that apply)
□ Emotions □ Physical Hunger □ Stress □ Boredom □ Time of Day □ Other:_____
How often do you eat until you are uncomfortably full? (daily, weekly, monthly)_____ □ Other_____
Have you ever felt like you cannot control the amount of food you are eating? □ Yes □ No
If yes, how often does this happen?_____
If you checked yes to reading food labels (above), what do you look for on food labels?_____
What is your typical eating pattern? (Check all that apply)
Week Day: □ skip meals □ night eating □ 3 meals/day □ 3 meals + snacks □ no pattern □ varies*
Weekend Day: □ skip meals □ night eating □ 3 meals/day □ 3 meals + snacks □ no pattern □ varies*
If you regularly skip meals, which ones and why?_____
*How does your meal and snack pattern vary on the weekend vs. during the week?_____
_____
Do any religious or cultural practices affect your diet? Please explain:_____
_____

I allow myself to eat foods I crave	□ Yes □ No	What foods do you crave?	
I avoid foods that are high in fat	□ Yes □ No	If yes, why?	
I avoid foods that are high in carbs	□ Yes □ No	If yes, why?	
I avoid foods that are high in calories	□ Yes □ No	If yes, why?	
I eat *diet foods on a regular basis	□ Yes □ No	*fat free, sugar free, low carb	
I avoid certain food groups	□ Yes □ No	If yes, which ones?	
I feel guilty when I eat a food that is "unhealthy"	□ Yes □ No	If yes, which foods?	
I do not allow myself to eat certain foods	□ Yes □ No	If yes, which ones?	
I trust that my body will tell me *when* to eat	□ Yes □ No	I think about burning calories when I exercise	□ Yes □ No
I trust that my body will tell me *what* to eat	□ Yes □ No	Sometimes I feel like food controls my life	□ Yes □ No
I trust that my body will tell me *how much* to eat	□ Yes □ No	I think about my weight greater than 50% of the day	□ Yes □ No
I think about food greater than 50% of the day	□ Yes □ No	I am scared of being overweight/gaining weight	□ Yes □ No

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Describe what "healthful eating" means to you: _____
_____
How many meals per week do you eat at a restaurant? _____ Which meals?_____
Which restaurants do you usually choose?_____
Who does the cooking in your household? _____ Do you like to cook? □ Yes □ No
How often do you/your family cook at home? _____ Who does the grocery shopping? _____
How often do you travel?_____
Do you feel that your schedule and other aspects of your life often conflict with a healthy eating program? □ Yes □ No
If yes, please explain:_____
What eating habits/behaviors are you proud of?_____
What eating habits/behaviors need the most improvement?_____

Eating Patterns, Behaviors & Attitudes Part 2: *Please check yes if you mostly agree with the following statements. Please check no if you mostly disagree with the following statements.*

I don't think I should eat past a certain hour at night	□ Yes □ No	At times I feel out of control when I'm eating	□ Yes □ No
I don't feel comfortable eating in front of others	□ Yes □ No	I don't like eating food without knowing nutrition info	□ Yes □ No
I plan meals and snacks for the day ahead of time	□ Yes □ No	I won't eat unless I can exercise after	□ Yes □ No
I become upset if I am unable to follow my plan	□ Yes □ No	I have "safe" foods and "unsafe" foods	□ Yes □ No
I eat the same foods almost every day	□ Yes □ No	I believe there are "good" foods and "bad" foods	□ Yes □ No
I am resistant to try new foods and/or add variety	□ Yes □ No	I feel guilty if I can't exercise when I plan to	□ Yes □ No
I compare what I'm eating to what others are eating	□ Yes □ No	I feel ashamed of my eating habits	□ Yes □ No

Have you ever struggled with an eating disorder (ED)?□ Yes □ No If yes, at what age did you notice initial behaviors? _____
Which ED? □Anorexia Nervosa (AN) □Bulimia Nervosa (BN) □Binge Eating Disorder (BED) □Eating Disorder NOS (EDNOS)

What were some of the initial symptoms/behaviors you noticed prior to the diagnosis?_____
_____

What was the progression of ED symptoms?_____
_____

What eating disorder thoughts, behaviors and symptoms have been most concerning to you in the past 6 months-1 year? (Example: restricting food intake, over-exercising, binge eating, irrational beliefs about food and body shape, weight loss/gain, purging) _____
_____
_____

Have you ever received treatment for an ED? □ Yes □ No If yes, when? Where?_____
_____
Do you have food and/ or meal rituals? □ Yes □ No Please list:_____
_____
Do you have food or eating rules? □ Yes □ No Please list:_____
_____

Goals:
What are your short-term goals for nutrition counseling?_____
_____

What are your long-term goals for nutrition counseling?_____
_____

Client Signature:_____ Date:_____

Dietitian Signature:_____ Date Reviewed:_____

Dietitian Notes:

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