16980 Dallas Pkwy
Suite 110
Dallas, TX 75248

Initial Visit and Food Questionnaire

Client Name: _____ Date: _____

Please answer each question below to the best of your ability.

- What interests you most about our DietMD® program?
- What goals do you want to achieve?
- Current height (H) and weight (W):
- What is your goal weight?
- How many calorie consuming events (CCEs) do you have per day?
  A calorie consuming event (CCE) is any snack or meal. Please check one number.
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6+
- Do you usually eat breakfast? ☐ Y ☐ N
- What are your typical mealtimes? Please write the usual time of each meal or snack.
  Breakfast: Lunch: Dinner: Snacks:
- Do you drink any liquids or semi liquids that contain calories? ☐ Y ☐ N
  Please check any of the liquids you consume on a regular basis.
  Note: water, black coffee, black tea are unrestricted.
  ☐ Fruit Juice ☐ Soda ☐ Diet Soda ☐ Smoothies ☐ Milk ☐ Milkshakes
  ☐ Energy Drinks ☐ Lemonade ☐ Beer ☐ Wine (red) ☐ Wine (white) ☐ Hard Liquor
- Do you sip on a calorie consuming beverage throughout the day or over several hours? ☐ Y ☐ N
- What are you eating now that you think is causing you to gain weight?
- What foods do you love but know are bad for you?

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- Do you have any food allergies? ☐ Y ☐ N If yes, list them below:
- Are there any foods you do not like or will not eat? ☐ Y ☐ N If yes, list them below:
- Are you vegetarian? ☐ Y ☐ N
- Do you eat eggs? ☐ Y ☐ N
- Do you have a history of kidney stones? ☐ Y ☐ N
- Do you have a history of gout? ☐ Y ☐ N
- Do have problems with constipation? ☐ Y ☐ N
- Do have problems with diarrhea? ☐ Y ☐ N
- Do you have a history of any of the following? (please check)

☐ Eating Disorder	☐ Bulimia	☐ Anorexia
☐ Gallstones	☐ Gallbladder Removal	☐ Kidney Failure
☐ Heart Failure	☐ Weight Loss Surgery	☐ Gastric Bypass
☐ Gastric Sleeve	☐ Lap Band	☐ Alcoholism
☐ Ulcerative Colitis	☐ Crohn's Disease	☐ Liver Disease/Cirrhosis
☐ Pancreatic Insufficiency	☐ Inflammatory Bowel Disease	

- What is your preferred way to learn new information? Please check your preferences.

☐ Watching Videos	☐ Reading Books	☐ Reading Websites	☐ All of these choices

- How do you prefer to track your progress when following a diet program? Please check your preferences.

☐ Phone Apps ☐ Website ☐ Paper Tracking ☐ No Tracking at All

- What is the longest amount of time you have gone without eating or drinking? (During illness does not count.) Please circle only one answer.

☐ Less than 12 hours	☐ 12 hours	☐ 16 hours	☐ 24 hours	☐ More than 24 hours

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- Have you tried a weight-loss or diet program in the past? If so, which programs?
- Do you feel like food controls you?
- Do you tend to eat because of your emotions?
- Do you snack after dinner and/or late at night?
- How committed to your health goals do you feel on a scale of 1-10?
- What was your weight when you graduated high school?
- Do you exercise? ☐ Y ☐ N If yes, how often?
- Please do a 24-hour recall of everything you have eaten.

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack: