EATING PATTERN QUESTIONNAIRE

Name _______________________________________________ Date ____________________________

Please answer the following questions and check the appropriate boxes that most closely describe your eating patterns.

1. Do you follow a special diet?  
   - No  
   - Low Fat  
   - Low Sodium  
   - Kosher  
   - Diabetic  
   - Vegetarian  
   - Other

Give examples of what guidelines or diets, if any, you follow: ____________________________________________

2. Which meals do you regularly eat?  
   - Breakfast  
   - Lunch  
   - Brunch  
   - Dinner

3. When do you snack?  
   - Morning  
   - Afternoon  
   - Evening  
   - Late night  
   - Throughout the day

What are your favorite snack foods? __________________________________________________________________________

4. Do you eat out or order food in?  
   - Yes  
   - No

How often?  
   - Daily  
   - Weekly  
   - Monthly  
   - Other

What kind of restaurant(s)/eating facilities? ________________________________________________________________

What kinds of cuisine? __________________________________________________________________________________

5. How is your food usually prepared? Check all that apply.
   - Baked  
   - Broiled  
   - Boiled  
   - Fried  
   - Steamed  
   - Poached  
   - Other

6. How many times each day do you have the following food items?
   - Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Fruit
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Vegetables
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Dairy (milk, yogurt)
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Meat, fish, poultry, eggs, cheese
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11
   - Sweets (candy, cake, regular soda, juice)
     - Never  
     - Less than 1  
     - 1-2  
     - 3-5  
     - 6-8  
     - 9-11

7. What beverages do you drink daily and how much?
   - Water  
     - ___ times or glasses per day (8oz)
   - Coffee  
     - ___ times or cups per day
   - Tea  
     - ___ times or cups per day
   - Soda  
     - ___ times or cups per day (12oz)
   - Alcohol  
     - ___ times or cups per day (12oz)
   - Other  
     - ___ times or glasses per day

(Specify) ______________________________________________________________________________________________

8. Would you like to change your eating habits?  
   - Yes  
   - No

Which habits would you like to begin to change? ________________________________________________________________________________________________