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?
a. Starch (bread, bagel, roll, cereal, pasta, noodles, rice, potato)
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
b. Fruit
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
c. Vegetables
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
d. Dairy (milk, yogurt)
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
e. Meat, fish, poultry, eggs, cheese
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
f. Fat (butter, margarine, mayonnaise, oil, salad dressing, sour cream, cream cheese)
_____ Never _____Less than 1 _____1-2 _____3-5 _____6-8 _____9-11
g. 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? _____

_____

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