



American
Health & Wellness
Center

Eating Patterns Questionnaire

Name _____

Please answer questions and check appropriate boxes that most clearly describe your eating patterns!

1. Do you follow a special diet?

- No Diabetic Low sodium
 Low Fat Kosher Vegetarian
 Other _____

2. Which meals do you regularly eat?

- Breakfast Lunch Brunch Dinner

3. When do you snack?

- Morning Afternoon Evening
 Late Night Throughout the day

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 kind of cuisine? _____

5. How is the food usually prepared
(check all that apply)

- Baked Broiled Boiled Fried
 Steamed Poached Other

6. How many times a day do you eat the following food items? Please Circle

A. Starch (bread, bagel, cereal, pasta)
never <1 1-2 3-5 6-8 9-11

B. Fruit
never <1 1-2 3-5 6-8 9-11

C. Vegetables
never <1 1-2 3-5 6-8 9-11

D. Dairy (Milk, yogurt)
never <1 1-2 3-5 6-8 9-11

E. Meat, Fish, Poultry, Eggs, Cheese
never <1 1-2 3-5 6-8 9-11

F. Fats (butter, mayo, oil, cream cheese)
never <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 glasses per day 12oz
 Alcohol ___ times or glasses per day 12oz
 Other ___ times or cups per day

Specify _____

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

Which habits would you like to begin to change? _____

9. What are your top 5 favorite foods?

