



Figure 4.1

## 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       Diabetic       Low sodium
- Low fat       Kosher       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 (8 oz)

Coffee      \_\_\_\_\_ times or cups per day

Tea      \_\_\_\_\_ times or cups per day

Soda      \_\_\_\_\_ times or glasses per day (12 oz)

Alcohol      \_\_\_\_\_ times or glasses per day (12 oz)

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?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_