Scottsdale
Mental Health & Wellness
INSTITUTE

Adult Nutrition Screening Questionnaire/ 18 and Older

Name:_____ Date:_____

Provider:_____ Date of birth: _____

Circle one: Male/ Female

Please answer the following questions to help our Provider learn more about your nutrition and physical health.

1. Do you ever eat to the point where you feel uncomfortable or out of control? Yes/No
2. Do you have trouble sleeping? Yes/No
3. Have you lost 10 or more pounds in the last 6 months? Yes/No
4. Have you gained 10 or more pounds in the last 6 months? Yes/No
5. Have you been on a weight reduction diet ? Yes/No
6. Have you had a recent change in appetite? Yes/No
7. Do you have any problems with :

    Swallowing Yes/No

    Chewing Yes/No

    Diarrhea Yes/No

    Constipation Yes/No

8. Do you have a history of, or are currently struggling with, an eating disorder, binge eating or emotional eating? **(CIRCLE ONE)** YES NO