

Nutrition Study Dietary Screening Form

Participant Information

Full Name

Age

Date

Gender

Dietary Habits

How many meals do you eat per day?

How many snacks do you have per day?

Do you follow any specific diet (e.g., vegetarian, vegan, gluten-free)?

Do you have any food allergies or intolerances?

Daily Intake Frequency

How often do you consume fruits?

How often do you consume vegetables?

How often do you consume whole grains?

How often do you consume sugar-sweetened beverages or foods?

Additional Information

Do you take any dietary supplements or vitamins?

Comments or Remarks