PULSE PEERS UNDERSTANDING LISTENING SUPPORTING EDUCATING
HEALTH EDUCATION

Name _____

Date _____

Location: Lower Level of Health Center
Phone: 805-756-6181

24 HOUR RECALL

Check Type of Day ○ Workday ○ Non-workday
○ School day ○ Weekend ○ Holiday

Is this a typical day of your eating habits? ○ **Y** ○ **N**

Do you follow a specific type of diet (i.e. vegan, vegetarian, lacto/ovo etc.)?

What are you interested in learning regarding your personal nutrition during the consultation?

Are there any specific nutrition-related topics (diet, trends, etc.) you would like to know more about?

Do you often feel hungry? ○ **Y** ○ **N**
(If your answer is yes, please answer the questions below)

Do you ever feel too hungry to study? ○ **Y** ○ **N**
Do you have access to a kitchen? ○ **Y** ○ **N**
Is your food supply low at the end of the month? ○ **Y** ○ **N**

TIME	LOCATION	DESCRIPTION OF FOOD EATEN/HOW PREPARED	AMOUNT EATEN
8:00AM	*Bus*	Cheerios without milk **(Example)**	*1 cup*

Updated Spring 2015

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TIME	LOCATION	DESCRIPTION OF FOOD EATEN/HOW PREPARED	AMOUNT EATEN