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Nutrition Consultation Intake Form

General Information **Date:**
Name:
Age:
Height: **Weight:**

Concerning your state of health, what is your major goal or objective?

Regarding your current Health Status, what are three major areas of concern for you?

1.
2.
3.

Regarding your Nutrition, what are three major areas of concern for you?

1.
2.
3.

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:
Significantly modify your diet
Take several nutritional supplements each day
Keep a record of everything you eat each day
Modify your lifestyle (e.g., work demands, sleep habits, exercise)
Practice a relaxation technique
Engage in regular exercise/physical activity
Have periodic lab tests to assess your progress

How much on-going support and contact (e.g., telephone, e-mail) from the nutrition coach would be helpful to you as you implement your personal health program?

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Allergy Information
Please list food allergies:

Please list non-food allergies:

What type of allergic symptoms do you experience?

Notes:

Medical History:

Please indicate below any health conditions that your doctor has diagnosed (provide the date of onset.

Gastrointestinal

- Irritable Bowel Syndrome
- Inflammatory Bowel Disease
- Crohn's Disease
- Ulcerative Colitis
- Gastric or Peptic Ulcer Disease
- GERD (reflux/heartburn)
- Celiac Disease
- Hepatitis C or Liver Disease
- Other Digestive

Cardiovascular

Inflammatory/Autoimmune

- Chronic Fatigue Syndrome
- Rheumatoid Arthritis
- Lupus SLE
- Poor Immune Function *(frequent infec*
- Severe Infectious Disease
- Herpes-Genital
- Multiple Chemical Sensitivities
- Gout

Metabolic/Endocrine

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Heart Disease (heart attack)
Stroke
Elevated Cholesterol
Irregular heart rate – Pacemaker
High Blood Pressure
Mitral Valve Prolapse/heart murmur
Other Heart & Vascular : Palpitations

Respiratory

Asthma
Chronic Sinusitis
Pneumonia
Sleep apnea
Bronchitis
Tuberculosis
Emphysema
Other

Cancer

Any type of cancer

Diabetes type 1 or 2 (please indicate)
Metabolic syndrome (insulin resistanc
Hypoglycemia
Hypothyroidism (low thyroid)
Hyperthyroidism (underactive thyroid)
Poly Cystic Ovarian Syndrome (PCOS
Genetic disorder
Other

Neurological/Mood

Depression
Anxiety
Autism
Seizures
Bipolar Disorder
ADD/ADHD
Multiple Sclerosis

Other

Kidney stones
Acne
Psoriasis
Urinary Tract Infections
Frequent Yeast
Eczema

Notes:

Please provide a list of medications and supplements that you take on a daily or regular basis

Medication/supplement *Amount if known* *Reason*

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Surgeries/Hospitalizations
Please list any surgeries or hospitalizations (include dates and your ages if known).

Family History
Please note any family history of the following diseases: heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, cancer, mental illness or addiction.
Notes:.

*Do you engage in moderate **cardiovascular** physical activity at least 3 days a week, for a minimum of 20 minutes duration?*
(brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.)

Notes:

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Total Activity Level:

Activity	**Type/Intensity** (low-moderate-high)	**# Days/Week**	**Duration** (minutes)
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Have you ever had a nutrition consultation?

Have you made any changes in your eating habits because of your health?

Do you currently follow a special diet or nutritional program?
Low fat, No Gluten, No Dairy, Low Carb, Vegetarian, No Wheat, High protein, Vegan, Low Calorie, Low sodium, Diabetic, Other.

Any recent history of weight gain or weight loss? *Please explain*

How many meals per day do you eat? How many snacks?

Do you avoid any particular foods? *If yes, describe.*

How many meals do you eat out per week?

Occupational Activity:

What is your occupation and activity level at work as a percent?

Sedentary- seated and not moving
Standing/Walking-including light duty tasks
Lifting or performing physical labor
Intense activity(Running, throwing, yelling)

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Report or highlight all the factors that apply to your current lifestyle and eating habits:
I changed the font to blue for current lifestyle and eating habits

Fast eater
Erratic eating patterns
Eating too much or too little
Late night eating
Dislike healthy food
Time constraints
Travel frequently
Do not plan meals or menus
Rely on convenience items
Family member have different tastes
Love to Eat
Eat because I have to
Have a negative relationship to food
Struggle with eating issues
Emotional eater (stress, bored, etc.)
Confused about food/nutrition
Frequently eat fast foods
Poor snack choices

Do you regularly eat…
Breakfast ?
Lunch?
Dinner?

Snacks?

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Do you drink alcohol? If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? If yes, # daily?

Do you use artificial sweeteners? If yes, which ones?

What does a typical day look like in terms of meals on a weekday, from the time you wake up to the time you go to sleep?

What does a typical day look like in terms of meals on weekend, from the time you wake up to the time you go to sleep?

What are the top three dietary changes do you think would make the most difference in your overall health?
1.
2.
3.

The biggest Challenge(s) to reaching my nutrition goals is/are?

In the past, I have tried the following techniques, diets, behaviors, etc. to reach my nutrition
goals:

What makes you feel better?

What makes you feel worse?

What is the lowest body weight that you have been comfortably able to maintain for at least 2 years in your adult life, since around age 30?

How committed are you to making dietary changes in order to improve your health? 1-5 1(not committed) 5 (nothing will stop me) 5

Do you have any other thoughts, questions, or concerns?

Please note, we also require a 3-day food log through a software program to better evaluate what you are eating and look at your micronutrients. You should have received the details for that but just contact me if needed at gharrison@source-e.net.