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Nutrition Counseling Intake Form

Name:____Date:__________

Address:____

City:__________________________State:__________Zip:____________

Home Phone:_____________Cell Phone:__________________

Birth date:________________Age:_________Gender: M / F

Email address:______________________________________

Married:___Separated:___Divorced:___Widowed:___Single:___Partnership:___

Live with:
Spouse:___Partner:__Parents:__Children:_________Friends:___Alone:_____

MEDICAL HISTORY:

- ❑ **High Blood Pressure**
- ❑ **Cholesterol:** **Total______LDL___HDL____**
- ❑ **Thyroid Disorder**
- ❑ **Heart Disease**
- ❑ **Diabetes**
- ❑ **Food Allergies / Sensitivities**
- ❑ **OTHER**

Explanations:____
____
____

Hospitalizations and Surgeries (types and dates):
____
____

Height: _________Weight: _________Are you happy at this weight?______

Weight History:
____
____
____

List prescription Medications (with dosage and reason for use):
____
____
____

List over the counter medications: (NSAIDS, Aspirin, Antihistamines, Laxatives, Tums,etc.):____
____

Vitamins/Minerals/Supplements:
____
____
____

Exercise: Y / N If so, what and how often:
____
____
____

Sleep:

Average hours of sleep per night: ___
Do you fall asleep easily? Y / N
Do you wake often during the night? Y / N
Do you wake up feeling rested? Y / N

Please list your current stresses:
____
____
____

Major Health Concerns:
____
____
____

Primary Health Goals:

1. ____
2. ____
3. ____
4. ____

TYPICAL FOOD INTAKE

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

Beverages: ____

Which of the following do you currently use?

Alcohol ___Wine ___Beer ___Pipes___Cigarettes ___Chew ___Cigars ___
Coffee ___Regular ___Decaf ___Number of cups/day, week? __________

Eating Habits:

Do you regularly skip meals? ☐Yes ☐No
Do you usually snack?
Do you eat out? ☐Yes ☐No
How often? ____
Do you order take out? ☐Yes ☐No
How often? ____
Do you eat fast food? ☐Yes ☐No
How often? ____
Who does the grocery shopping? ____
Who prepares/cooks the meals? ____
Do you read food labels? ☐Yes ☐No
What do you look at on the label? ____
Do you eat standing up? ☐Yes ☐No
Do you eat in the car? ☐Yes ☐No
Do you eat in front of the tv? ☐Yes ☐No
Do you eat while reading, on the computer, etc? ☐Yes ☐No
Do you eat with others? ☐Yes ☐No
Do you eat faster/slower than others? ☐Yes ☐No
Do you eat when you are stressed? ☐Yes ☐No
Do you eat when you are bored? ☐Yes ☐No
Do you eat when you are lonely? ☐Yes ☐No
Do you eat when you are not hungry? ☐Yes ☐No
Do you know what hunger & fullness feel like? ☐Yes ☐No
Do you avoid certain foods? ☐Yes ☐No
Please Specify: ____
What are your favorite foods? ____
What food don’t you like? ____