Nutritional Counseling Intake Form

Demographic Information

Client Name				**Today's Date**	
Address				**Home Phone**	
				Office / Cell Phone	
Gender M F	**Age**	**DOB**		**Email**	
Height	**Weight**			**Place of Birth**	
Relationship status:				**Pets:**	
Children + ages:					
Occupation:				**Hours of work per week:**	

Health History

Please list your main health concerns:			
At what point in your life did you feel best?			
Any serious illnesses/hospitalizations/injuries?			
What is your ancestry?			
How is/was the health of your mother?			
How is/was the health of your father?			
What blood type are you?			
How is your sleep?	How many hours?	Do you wake up at night?	If so, Why?
Any pain, stiffness or swelling?			
What role does sports and exercise play in your life?			
Constipation/Diarrhea/Gas?	Please explain:		
Allergies or sensitivities?	Please explain:		

Notes

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Do you take any supplements or medications? Please list:	
Any healers, helpers or therapies with which you are involved?	Please list:
Have you had any lab or physical exam abnormalities recently?	If so, can you share them?

Women's Health

Are your periods regular?	How many days is your flow?	How frequent?
Painful or symptomatic? Please explain:		
Reached or approaching menopause? Please explain:		
Birth control history:		
Do you experience yeast infections or urinary tract infections? Please explain:		

Nutrition History

Have you ever had a nutrition consultation?	
Have you ever made any changes in your eating habits because of your health?	
Describe:	
Do you currently follow a special diet or nutritional program?	If so, please describe:
How often do you weigh yourself?	
Do you avoid any particular foods?	If so, types and reason
Do you grocery shop?	If no, who does the shopping?
Do you read nutrition labels?	

Notes

Do you cook?	If no, who does the cooking?
How many meals do you eat out per week?	
Do you crave sugar, coffee, cigarettes, alcohol or have any major addictions?	

Check all the factors that apply to your current lifestyle and eating habits:

Erratic eating pattern	Non-availability of healthy foods
Poor snack choices	Late night eating
Dislike healthy food	Time constraints
Eat more than 50% meals away from home	Travel frequently
Do not plan meals or menus	Fast eater
Reliance on convenience items	Eat too much
Significant other or family members don't like healthy foods	Love to eat
Significant other or family members have special dietary needs or food preferences	Struggle with eating issues
Eat because I have to	Emotional eater (eat when sad, lonely, depressed, bored)
Have a negative relationship to food	Eat too much under stress
Eat too little under stress	Eating in the middle of the night
Don't care to cook	Confused about nutrition advice

Notes

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Your Nutrition Goals

What is the most important thing you will change about your diet in order to improve your health?

Will family and/or friends be supportive of your desire to make food and/or lifestyle changes?

Who are they?

Which of these topics interest you?

Supermarket shopping tour	Weight management	Healthy snack and meal preparation	Fiber
Food labels	Eating out	Portion size	Meal planning

Please check one of the following to indicate the amount of structure you believe meets your needs:

Just tell me exactly what to eat for all my meals and snacks. I want a detailed food plan.

I want a lot of structure but freedom to select foods. I want to use the exchange system.

I want some structure and freedom to select foods. I want to use a food group plan.

I don't want a diet. I just want to eat better. I will just set food goals each week.

Weight Goals (if applicable):

	Current Weight
Weight one year ago +/- 5 lbs	Desired Weight Range +/- 5 lbs
Highest Adult Weight	Lowest Adult Weight

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Save this for the day of your first appointment.

24-Hour Diet Recall

Food

Time	Place	Meal	Food / Beverage Item	Details / Ingredients / Preparation	Beverage

Vitamins, Minerals, Medications, Supplements

Type/Brand of Supplement	Reason for Taking	Amount Taken (dosage)	Frequency of Dose (times/day)

Would you consider your intake of foods and beverages today to be typical of most days? Please explain:

List all physical activity for the day:

Notes

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