NUTRITION INTAKE FORM

Please fill out the following questions as best you can. If there is a particular question you don't understand or want to fill out, we can discuss them at our first meeting. Thank you.

Name_____ Date_____

Phone (h)_____(w)_____ (c) _____

Address_____

City_____ State _____ Zip Code _____

Email _____ Referred by _____

Insurance _____ ID# _____

Group #_____ Subscriber _____

Personal Information

Birthday _____ Age _____ Height _____ Weight _____ Gender ☐ M ☐ F

Ethnicity _____ Marital Status _____Children_____

Occupation _____ Hours in regular work week _____

What is the main reason for your visit? _____

Are you seeing any other health professionals at this time? ❑ Y ❑ N If yes, please list _____

_____

How well do you sleep?_____ Bedtime _____Waking time _____

On a scale of 1-10 (10 being the highest) how would you rate your stress level? _____

What causes stress for you? _____

List any regular physical activities (frequency and duration) _____
_____

List other hobbies or passions? _____

Do you smoke? ❑ Y ❑ N How much? _____

Do you drink alcohol? ❑ Y ❑ N How often? _____

Use recreational drugs? ❑ Y ❑ N Type/how often? _____

Health History (please mark and X in the box for either yourself and/or family members)

Condition	Self	Mother	Father	Grand Parent	Condition	Self	Mother	Father	Grand Parent
Heart Disease					Drug Abuse				
Cancer					Alcohol Abuse				
Autoimmune					Hepatitis				
Allergies					Chronic Pain				
Depression					Lungs/Chest				
Arthritis					Skin				
Diabetes					Gallbladder				
HIV/AIDS					Reproductive				
Thyroid Disorder					Stroke				
High Blood Pressure					Osteoporosis				
Migraines					Bone Fractures				
PMS					Gastrointestinal				

Any other conditions not mentioned above? anemia, crohns, colitis, ulcers, chronic infection cold/flu: _____

How would you describe your overall health? _____

Recent weight loss or weight gain? ❑ Y ❑ N If yes, how much? _____

Do you have any know allergens? ❑ Y ❑ N If yes, list allergy and symptoms _____

_____

Do you know your blood type? Circle: ❑ A ❑ B ❑ AB ❑ O

Medications/Supplements	Dosage	Frequency

Nutrition and Dietary Habits

How many meals do you typically eat per day? _____ Do you snack? _____

How many times a week do you:

eat out at restaurants? _____ eat breakfast? _____

cook meals at home? _____ grocery shop? _____

Do you normally eat alone or with friends/family? _____

Where do your grocery shop? _____

What is your weekly budget? _____ Do you read food labels? ❑ Y ❑ N

What is your favorite meal? _____

What are your favorite restaurants? _____

What 3 foods could you never give up?

_____

_____

_____

What 3 foods do you refuse to eat?

_____

_____

_____

How much water do you drink per day? _____ Foods you crave? _____

Do you drink coffee? ❑ Y ❑ N how much? _____

sodas? ❑ Y ❑ N how much? _____

Do you have any food allergies? ❑ Y ❑ N List: _____

What are your allergy symptoms? _____

Have you tried any popular diets? ❑ Y ❑ N Which ones? _____

What was your experience?

_____

What is your present diet: ❑ vegetarian ❑ vegan ❑ gluten free

❑ dairy free ❑ kosher ❑ other? _____

Are you pleased with your present diet? ❑ Y ❑ N What would you like to change? _____

_____

Have you tried to make these changes? ❑ Y ❑ N

What influences your food choices:

❑ Taste ❑ Nutrition ❑ Price ❑ Convenience ❑ Family Members ❑ Friends

How often do you have a bowel movement? _____ List any problems or issues?_____

_____

Eating Patterns: (check all that apply)

❑ eat too much	❑ eat too little	❑ forget to eat
❑ emotional eater	❑ eat out of boredom	❑ hungry all the time
❑ late night snacking	❑ fast eater	❑ eat in the car
❑ poor choices	❑ healthy choices	❑ no joy in eating

What do you consider healthy food choices? _____

_____

What do you consider poor food choices? _____

_____

How often do you eat the following foods in an average day/week?

Food	Servings day/week	Food	Servings day/week	Food	Servings day/week
Fruits		Pork		Pasta	
Vegetables		Nuts/Seeds		Bread	
Whole Grains		Dairy		Fried Foods	
Red Meat		Eggs		Fast Food	
Poultry		Soy Products		Juice	
Seafood		Legumes		Desserts/Sweets	

Women Only: Check those that apply.

❑ Perimenopausal ❑ Menopausal

❑ Regular periods ❑ Irregular periods ❑ Pregnant (how many months? _____)

Do you suffer from PMS? ❑ Y ❑ N If yes, please describe_____

_____

Are you taking any birth control? ❑ Y ❑ N If so, for how long _____

Are you taking any hormone replacement? ❑ Y ❑ N Please describe _____

_____

Please list any other additional information that you feel would be helpful:

_____

_____

CLIENT AGREEMENT AND RELEASE

I, _____, understand that Michelle Strand will provide me with professional nutritional evaluation, therapy, and support for the purpose of enhancing health. I understand that Nutrition Therapy is not intended as a diagnosis, treatment, prescription or cure for any disease, mental or physical, and is not intended as a substitute for regular medical care. No medical procedures are performed and no medications are prescribed with Nutrition Therapy.

This agreement is being signed voluntarily and not under duress of any kind.

Name_____

Address_____

City_____ State_____Zip_____

Daytime phone_____

Email _____

Signature_____ Date_____