Nutrition Intake Form

Name	
Date	
Contact Number #	
Date of Birth:	
Email:	
Mailing Address:	
Weight	
Height	
Cholesterol level	
Blood Pressure	
Reason for visit	
Have you lost or gained any weight in the last year?	
Have you had any major surgeries? Yes\ No If yes please explain:	

Allergies	
Do you smoke? Yes \ No	
What is your personal health like?	
What is your energy level on a scale of 1-10?	
How often do you work out Light, Moderate, Hard Core	
How many steps a day do you reach?	
What medications are you on? Please include name, dosage, and frequency?	
Does your GP know you are seeing a nutritionist?	
What supplements are you on? Please include name, dosage, and frequency?	
How often do you have a bowl movement? Type?	
What challenges do you believe stand in the way of your goals?	

Do you drink alcohole? If yes, how much and when?	
Food likes & dislikes	