Nutrition Intake Form

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Name: _____ Date: _____
Last First (Legal) Preferred First

Phone: ( ) _____ Email Address: _____

Address: _____ City, St, Zip: _____

Age: _____ Gender: ☐ M ☐ F

Referred by: ☐ Self Name? _____

Have you seen a nutritionist before? ☐ Yes ☐ No
If so, who and when? _____

Why do you want to see a nutritionist? (Check all that apply)

_____ Celiac or Gluten Sensitivity	_____ General healthy eating advice
_____ Vegetarian/Vegan eating	_____ Food Allergy or Sensitivities
_____ Irritable Bowel Syndrome	_____ Diabetes
_____ High blood pressure	_____ Disordered eating concerns
_____ Want to gain weight	_____ High cholesterol
_____ Want to lose weight	_____ Other (please specify) _____

Height: _____ Current weight: _____ Desired weight: _____

Lowest adult weight: _____ When: _____
Highest adult weight: _____ When: _____

(Use back side if more room is needed)

Does your food or weight feel out of control? ☐ Yes ☐ No

Are you currently being treated for a medical condition? ☐ Yes ☐ No
List _____

Are you taking any medications? ☐ Yes ☐ No
List: _____

Are you taking any vitamin or nutritional supplements? ☐ Yes ☐ No
List: _____

Do you have any family history of diabetes, high blood pressure, high cholesterol? ☐ Yes ☐ No
Which/Who: _____

_____

Do you drink alcoholic beverages? ☐ Yes ☐ No
Describe use (truthfully): _____

_____

Are you currently on a special diet?
(i.e., vegetarian, low-carb, gluten-free, etc) ☐ Yes ☐ No
Describe: _____

_____

What barriers, if any, stand in the way of you achieving your nutritional goals?

_____

_____

_____

Where do you eat most often? ☐ Home ☐ Restaurant
Other: _____

What is your favorite food? _____

_____

What foods will you absolutely not eat or try? _____

_____

_____

List any exercise/activity that you do on a regular basis:

Type of exercise/activity	Days per week	Time spent doing that activity (each time)

Describe changes, if any, that you have made to your eating and/or exercise habits. When did you implement these changes?

What do you hope to achieve as a result of nutrition counseling?

Rate how important this change is to you (0 not at all, 10 extremely).
0 1 2 3 4 5 6 7 8 9 10

Rate how confident you are to make this change at this time (0 not at all, 10 extremely).
0 1 2 3 4 5 6 7 8 9 10

Rate your stress level at this time (0 not at all, 10 extremely).
0 1 2 3 4 5 6 7 8 9 10

What, if any activities do you do to reduce your stress level? Describe:

Are your family members or housemates supportive of your dietary needs? Or do you feel they sabotage your success?

Signature Date

Do not write below this line