Rayanne Petersen
Nutrition Network

NEW CLIENT INTAKE FORM

Please complete this form using as much detail as possible. Feel free to attach a separate page if you need more space.

Any personal and/or medical information provided within this form and over the duration of the program will be kept in the strictest confidence.

PERSONAL INFORMATION	
Name & Surname:	Address:
Phone #:	Email address:
Age:	Height:
Preferred pronouns:	Preferred method of contact:
Current weight:	Goal weight (if applicable):
Ethnic background/ ancestry:	
Emerg. Contact Name:	Emerg. Contact #:

PERSONAL GOALS			
What are the most important things that you would like to change about your current state of health or nutrition?			
Please select any and all of the following goals that are appropriate for you at this point in your journey, or add your own below:			
	Improve overall health and wellbeing		Gain more knowledge about nutrition and metabolic health
	Lose weight		Optimize athletic performance
	Build muscle mass		Optimize brain health for longevity
	Overcome existing health problems / chronic diseases		Focus on preventative health care for longevity
	Reclaim ancestral diet		
On a scale of 1 to 10, how does your physical health feel on an average day? *(1 being very unwell, 10 being very healthy)*			
On a scale of 1 to 10, how does your mental health feel on an average day? *(1 being very unwell, 10 being very healthy)*			
Have you previously noticed if your daily food and beverage intake has an effect on your mental and physical wellbeing?			

Do you participate in any sports or other physically demanding activities, either recreationally or professionally? If so, which ones?
Do you participate in any other activities in which you would like to maximize your mental or physical performance? (chess, music, visual arts, gaming etc) If so, which ones?
What are your goals for progressing in your chosen sports or activities? Please describe short term and long term goals, if possible.
What motivated you to seek out professional nutritional coaching at this specific point in your journey?
What do you hope to achieve by the end of your program? Please provide as much detail as possible.
DIET HISTORY
Have you tried any version of a low-carb diet before? If yes, please describe your overall experience/ results.
Have you tried any other diet or nutrition plans before? If yes, which ones? What aspects of them worked for you, and what didn't work?
How would you describe your relationship with food, currently and/or historically?

How would you describe your relationship with your physical body, currently and/or historically?
Do you turn to food as a source of comfort in emotional moments? If yes, what kinds of foods do you tend to seek out when you feel emotional?
Do you tend to eat large meals or graze on smaller items throughout the day? What is usually your biggest meal of the day?

How many meals do you currently eat on an average day?	How much water do you drink on an average day?
Do you weigh yourself? If yes, how often?	Do you currently track your caloric intake? If yes, what is your average daily intake?
Do you smoke cigarettes? If yes, how much/ how often?	Do you consume alcohol? If yes, how much/ how often?

What were mealtimes like when you were growing up? How did your parents / caretakers / family members talk about food, body image, health and nutrition?
Have you ever struggled with an eating disorder, currently or historically? If so, have you received/are you receiving any form of treatment? Please describe any specific triggers/ ongoing health issues I should be aware of in this regard.
Do you have any food allergies? If yes, please list them here.

SLEEP AND STRESS	
How many hours of sleep do you get on an average night?	What is the average quality of your sleep?
Do you take any sleep aid medication or supplements? If so please list:	
Please describe your pre-sleep routine on an average night. What do you usually do to wind down in the hour(s) before bed?	
Do you consider yourself a morning person or a night owl?	

What are your usual coping mechanisms for dealing with stress?
How often do you feel that you are under more pressure or stress in life than you can handle?
Do you struggle with mental illness in any form (clinically diagnosed or self-diagnosed)? If so, have you received/are you receiving any form of treatment? Please describe any specific triggers/ ongoing health issues I should be aware of in this regard.
Do you currently have a support network in place to help you through times of added stress in your life?

EXERCISE

How many times do you exercise on an average week?	Do you enjoy exercising?
What kinds of exercise do you prefer?	
Do you currently have any injuries? If yes, please specify:	
Do you have any chronic pain? If yes, please specify:	
Are you currently undergoing any form of treatment for the abovementioned injuries and/or chronic pain? If so, please specify:	
Mark the one that best describes you, or use the space below to write your own description:	

	Beginner: light to moderate exercise, up to 3 times per week, 23-30 minutes per session.		**Intermediate:** recreational athletes, exercising 4-5 times per week for 30-45 minutes.
	Advanced: pre-professional or professional athletes, training 5-6 times per week for 60 minutes or more.		**Strength Focus:** strength & power athletes, ie body builders, weight lifters etc.

NEURODIVERGENCE

If you identify as neurodivergent and would like to request accommodations of any kind, please use the following space to let me know how I can best support you:

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MEDICAL INFORMATION

Please mark any and all boxes that fit your profile, whether they have been clinically diagnosed or are suspected/ self-diagnosed. If you have a medical issue not listed below, please clarify on the next page.

*Clients with any of the following * conditions MUST be working in conjunction with their current medical service provider.*

MEDICAL HISTORY	YES	MEDICAL HISTORY	YES
***Diabetes/IR**		***Metabolic**	
Diabetes Type 1 on Insulin		Gout/ Kidney Stones	
Diabetes Type 2 on Insulin		Hypothyroidism	
Diabetes Type 2 on medication		Hyperthyroidism	
Insulin Resistant		Coronary Artery Disease	
***Cardiac**		Excessive Uric Acid	
Very high blood pressure (Hypertension)		**Gastrointestinal Tract**	
Heart failure		*Peptic Ulcer	
Previous MI (Myocardial Infarction) heart attack		*Cholecystectomy/ Gallstones	
Low blood pressure (Hypotension)		*Crohn's Disease	
Cardiovascular Disease (CVD)		*Ulcerative Colitis	
***Renal (Kidney)**		*Blood in stool	
Dialysis		Irritable Bowel Syndrome (IBS)	
Poor kidney function		Stomach cramps	
Transplant		Constipation	
***Autoimmune Disorders**		Severe constipation	
Rheumatoid Arthritis (RA)		Lazy bowel	
Systemic Lupus Erythematosus (SLE)		Bloating	
Celiac Disease		Heartburn	
Multiple sclerosis		Acid Reflux / GERD	
Graves Disease		Hiatal hernia	
Other (specify):		Lactose intolerance	

MEDICAL HISTORY	YES	MEDICAL HISTORY	YES
***Fertility/Pregnancy**		***Mental Health**	
Pregnant		Eating disorder	
Breastfeeding		Substance abuse	
Actively trying to become pregnant		Alcoholism	
Taking fertility treatments		Severe stress (chronic or acute)	
Undergoing IVF		Depression	
Endometriosis		PTSD / C-PTSD	
Perimenopause		Anxiety	
Menopause		Body Dysmorphic Disorder	
On Hormone Replacement Therapy (HRT) for menopause		Personality Disorder	
On hormonal birth control		Obsessive-Compulsive Disorder (OCD)	
Other Health Issues		Severe phobias (specify):	
*Cancer (specify):		***Cholesterol**	
*Undergoing chemotherapy		Very high	
*Medication - Warfarin		Familial hypercholesterolemia	
*Terminal Disease (specify):		**Menstrual**	
Water retention		Polycycstic Ovary Syndrome (PCOS)	
Hormone imbalance		Premenstrual Dysphoric Disorder (PMDD)	
*Asthma		Dysmenorrhea (excess period pain)	
Osteoporosis		Amenorrhea (absent periods)	
Headaches		**Deficiencies (please specify)**	
Muscle soreness/stiffness		Vitamins	
Allergy (please specify)		Minerals	
Food		Omegas	
Medication		Aminos	
Other:		Other:	

If you answered YES to any of the above, please use the space below to provide more information about your condition(s) and/or treatment. Feel free to attach a separate page if you need more space.

Please list any medications that you are currently taking, or plan to start taking over the course of your program. This includes prescription medications, hormone treatments, birth control, as well as OTC vitamins, natural supplements, steroids, diet pills, laxatives, recreational drug use etc.

Clients who are on chronic medication MUST consult their doctors for assistance in adjusting medications as necessary.

Medication/ Supplement Type	**Reason for Taking It**

Have you had any blood tests done recently? If yes, please provide details about why the tests were done & which biomarkers were tested. If possible, please attach a copy of your test report/results.

Please complete the following section with as much detail as possible. Use a separate page if necessary.

Track your normal food and beverage intake for two days, and record it in the space below. Do not change anything about your usual diet - it should be as close as possible to what you regularly eat on an average day.

Please be as specific as possible – If you make a salad, write down what was in the salad. If you have a shake, write down what was in the shake. If you are eating takeout or at restaurants, write down as many of the ingredients as you can, within reason. Include all of your snacks and beverages.

DAY 1	
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Dessert	
Beverages	

DAY 2	
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Dessert	
Beverages	

NB: If I find that you are a high-risk patient, based on your medical history, I will request a doctor's certificate from you that clears you to participate in this program. The note must confirm that you will be working alongside your medical service provider for the duration of the program.

Thank you!

Rayanne Petersen