Patient Intake Form

The Real Food Life

Nutrition Consulting with Christine Donovan, CNC

PERSONAL INFORMATION

FULL NAME

EMAIL ADDRESS

PHONE NUMBER

ADDRESS

OCCUPATION

DATE OF BIRTH

AGE

SEX

- [ ] MALE
- [ ] FEMALE

EMERGENCY CONTACT (NAME AND PHONE)

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MEDICAL HISTORY

PRIMARY CARE PHYSICIAN

DATE OF LAST PHYSICAL EXAM

CURRENT MEDICAL CONDITIONS

PAST MEDICAL CONDITIONS OR SURGERIES

FAMILY HISTORY OF ILLNESS (E.G., DIABETES, HEART DISEASE)

CURRENT MEDICATIONS (INCLUDE DOSAGE)

VITAMINS OR SUPPLEMENTS

ALLERGIES (FOOD, MEDICATION, ENVIRONMENTAL)

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LIFESTYLE & HABITS

TYPICAL WORK SCHEDULE

SLEEP (HOURS PER NIGHT)

ENERGY LEVEL (1–10)

EXERCISE (TYPE, FREQUENCY, DURATION)

TOBACCO USE

☐ YES

☐ NO

ALCOHOL USE

☐ YES

☐ NO

IF YES, HOW OFTEN?

CAFFEINE USE

☐ YES

☐ NO

IF YES, TYPE/AMOUNT?

ANY ADDITIONAL INFORMATION OR NOTES

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DIETARY HABITS

HOW MANY MEALS DO YOU EAT PER DAY?

HOW MANY SNACKS PER DAY?

WHO PREPARES YOUR MEALS?

DO YOU FOLLOW ANY SPECIFIC DIET (E.G., VEGAN, KETO, GLUTEN-FREE)?

FOOD DISLIKES OR AVERSIONS

FOOD CRAVINGS OR EMOTIONAL EATING PATTERNS

FOOD ALLERGIES OR INTOLERANCES

ANY ADDITIONAL INFORMATION OR NOTES

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DAILY FLUID INTAKE

BEVERAGE	AMOUNT PER DAY	BEVERAGE	AMOUNT PER DAY
WATER		JUICE	
COFEE OR TEA		ALCOHOL	
SODA OR ENERGY DRINKS			

GOALS & CONCERNS

PRIMARY REASON FOR VISIT

HEALTH OR NUTRITION GOALS

SPECIFIC CONCERNS OR SYMPTOMS

HOW MOTIVATED ARE YOU TO MAKE DIETARY CHANGES? (1–10)

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CONSENT & PRIVACY

I understand that the information I have provided will be kept confidential and used solely for nutritional assessment and planning purposes.

SIGNATURE	
DATE	