

# Patient Intake Form

The Real Food Life

Nutrition Consulting with Christine Donovan, CNC

## PERSONAL INFORMATION

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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

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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

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### 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

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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

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BEVERAGE	AMOUNT PER DAY	BEVERAGE	AMOUNT PER DAY
WATER	<input type="text"/>	JUICE	<input type="text"/>
COFFEE OR TEA	<input type="text"/>	ALCOHOL	<input type="text"/>
SODA OR ENERGY DRINKS	<input type="text"/>		

## GOALS & CONCERNS

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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

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

**SIGNATURE**

**DATE**

