Minimum Nutrition
Nutrition Education & Counselling

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Health History Intake Form

Minimum Nutrition aims to provide clients with the best possible nutrition care. For this to occur, health information must be accurate and up-to-date. Please complete the following information:

Client Information Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Master ☐ Dr ☐ Other ….		
Name:		Date:
Age:	DOB:	Gender:
Occupation:		
Address Details:		
Suburb:	State:	Postcode:
Home Phone:		
Mobile Phone:	Work Phone:	
Email Address:		
Emergency Contact Name:	Relationship:	
Emergency Contact Phone Number:		
Usual GP & Clinic:	Phone:	
Live with: ☐ Alone ☐ partner/spouse ☐ parents/guardians ☐ share with friends ☐ dorm style ☐ other **Please indicate who does the shopping/cooking:**		
Preferred Method of contact to confirm appointments: SMS to Mobile phone: ☐ Email: ☐ Both: ☐		
How did you find out about Minimum Nutrition? ☐ Facebook Page ☐ Google/other search engine ☐ Magazine/Newspaper ☐ Our Email/Newsletter ☐ Our Website ☐ Word of Mouth ☐ Practitioner referral		
Your main nutrition-related health concern/s: **1.**		
2.		
3.		
Personal nutrition-related goal/s: **1.**		
2.		
3.		

Past and Current Medical History

Have you had a general medical check-up in the last six (6) months? ☐ YES ☐ NO

Provide details of current health problems or illnesses:

Provide details of previous health problems or illnesses:

Provide details of any prescription medications you are currently on:

Provide details of any supplements you are currently taking:

Do you currently smoke? ☐ YES ☐ NO
If YES, how much do you smoke per day?

Have you previously been a smoker? ☐ YES ☐ NO

Do you drink alcohol? ☐ YES ☐ NO
If YES, how many standard drinks would you have in an average week?

Does anyone in your family have a history of the following conditions? *(Give more details where appropriate)*

Diabetes	☐	
Heart Disease	☐	
High Blood Pressure	☐	
High Cholesterol	☐	
Allergies	☐	
Food intolerance	☐	
Anaemia	☐	
Thyroid conditions	☐	

Exercise

Are you currently physically active? ☐ YES ☐ NO

Exercise/Sports training schedule (*include competitions/games*):

Day	a.m. training	Mid-day training	p.m. training
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

Rate your level of motivation for including exercise into your life? ☐ Low ☐ Medium ☐ High
List any concerns that limit your activity:

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No
If yes, please describe:

Stress/Coping

Have you or are you seeing a psychologist or counsellor? ☐ YES ☐ NO

Do you feel you have an excessive amount of stress? ☐ YES ☐ NO

Daily Stressors: *(rate on a scale of 1-10, 1=least & 10=worst)*

☐ Work	☐ Family	☐ Social
☐ Finances	☐ Health	☐ Other

Do you practice meditation or relaxation techniques? ☐ YES ☐ NO
If yes, select those that apply:

☐ Yoga	☐ Meditation	☐ Imagery	☐ Breathing
☐ Tai chi	☐ Prayer	☐ Walking/Exercise	☐ Other

Nutrition and Diet History

Have you made any changes to your eating habits because of your health? ☐ Yes ☐ No
Describe:

Are you, or have you ever been on a restricted diet? ☐ Yes ☐ No
If yes, please describe:

Do you avoid any particular foods? ☐ Yes ☐ No
If yes, explain reason:

List below the times you have the following meals and what you would normally eat at each:

Meal	**Time**	**Normal food intake**
Breakfast		
Morning tea		
Lunch		
Afternoon tea		
Dinner		
After dinner		

What foods would you usually have for general snacks?

What types of foods do you usually crave?

Do you feel like you are frequently hungry?

Lifestyle and Eating habits: (check all that apply)

☐ Erratic eating pattern	☐ Eating late at night	☐ Frequent over-eating	☐ Eat fast/slow
☐ Travel/away from home often	☐ Stress under-eating	☐ Stress over-eating	☐ Negative relationship with food
☐ Not enough time to cook	☐ Eat out frequently	☐ Other	