CONFIDENTIAL INTAKE FORM

Name:_____ Today's Date: _____

Phone number: _____ Email address: _____

Occupation: _____ Date of Birth: _____

Height: _____ Weight:_____ Ideal Weight:_____

Do you have nutrition knowledge?_____

Reason for visit: _____

_____

Are you under a clinician's care for a condition or illness?_____

Who is your primary care physician?

_____

For which condition/illness? _____

Have you been diagnosed by a clinician for a nutrition-related problem (such as anemia, high cholesterol, hypoglycemia, gastrointestinal problem, thyroid disorder, etc.)?_____
If yes, please specify:

_____

If you believe you have a nutrition-related problem or metabolic disorder, you must see a clinician for an accurate diagnosis.

What if anything, have you done previously to manage your nutrition-related concerns?

_____

Current medications:

_____

_____

Vitamins/minerals/herbal supplements:

_____

_____

Reasons for taking: _____

Do you exercise? _____ If not, why? _____

Type of exercise	How many times/week?	How long do you exercise?
_____	_____	_____
_____	_____	_____
_____	_____	_____

How many hours of sleep do you get daily? _____

Do you have any religious or ethnically specific food preferences? _____

If yes, specify: _____

Food dislikes:

_____

Food allergies/intolerances:

_____

Who plans your meals?_____Who cooks?_____

Who shops? _____ Is a list used?_____

How often do you eat out/week? _____

Do you drink alcohol?_____What type?_____Weekly amount:_____

Do you drink coffee or tea?_____Reg/Decaf? _____ Daily amount:_____

Do you drink soda? if so daily amount

_____

What other beverages? _____ Daily amount:_____

What do you feel are your "worst" food habits?

_____

_____