Comprehensive Nutrition Intake Form

Please complete this form at least 24 hours before our first appointment.

Personal Information

Last Name: ____________________________________ First Name: ________________________________

Address: ____ Apt#: ______

City: ____ State: ______ Zip Code: _____________

Phone #: _________________________ Cell #: _____________________ EMAIL: __________________________________

Date of Birth: _______________________ Age: _______ Gender: ______________ Marital Status M S D

Occupation: ____

Hours per week: _____________ Referred by: ____

Health Care Providers

Do you work with a specialist in addition to your primary care provider? Yes No

Specialist Provider

Please add information for any other physician you routinely see (e.g. nephrologist/kidney doctor, endocrinologist/diabetes doctor, cardiologist/heart doctor)

Title: _________________________ First Name: _________________________ Last Name: ________________________________

Address: ____ Apt#: ______

City: ____ State: ______ Zip Code: _____________

Phone #: _________________________ Cell #: ______________________ Fax #: ___________________

EMAIL: __________________________________

Family History

Are you aware of any medical problems or illnesses in your blood relatives? Yes No

Paternal Family Illnesses

Paternal Family Member	Health Condition/Illness

Maternal Family Illnesses

Maternal Family Member	Health Condition/Illness

Personal Health History

Height: _________ Current weight: _________ Typical weight: _________

Highest weight: _________ Date: ______________

Lowest weight: _________ Date: ______________

Have you noticed any recent changes in your weight? Yes No

Please describe in detail.

Has anyone expressed concern about your weight? Yes No

Please describe in detail.

Are you currently pregnant or breastfeeding? Yes No

Do you have any current or past health issues diagnosed by a medical doctor or other health professional? Yes No

Medical/Mental Health Diagnoses

Diagnosis	Current	Past	Date of Onset

Have you been hospitalized or had any surgical procedures in the past? Yes No

Past Hospitalizations/Surgeries

Hospitalization/Surgery	Date	Reason

Medications and Supplements

Have you ever taken antibiotics? Yes No

When was the last time you were on a course of antibiotics? _________________

Have you ever taken birth control? Yes No

If so, when? ______________________

Have you ever used diet pills, laxatives or diuretics in an effort to control your weight? Yes No

Medications and Supplements
List all medications you're currently taking. Please include any over-the-counter vitamins, minerals, protein shakes, meal replacements or herbal remedies, even if they are not prescribed by your physician.

Medication	Dose	Frequency	Start Date	Purpose

Gastrointestinal

How often do you have a bowel movement?

At least daily Every 2-3 days Less than twice per week

Do you experience digestive difficulties? Yes No
(i.e. bloating, constipation, gas, indigestion)

Please describe:

Please check off any of these common bowel issues that you experience. Please be sure to include any medications you use for your gut health in the medication list above.

Straining to have bowel movements
Loose stools
Constipation
Bloating/gas
Daily/frequent use of laxatives
Daily/frequent use of stool softeners
Diarrhea
Acid reflux/indigestion

How much does this impact your day-to-day life and routines?
1=Little/rarely, 10=Debilitating or almost every day __________

Allergies

Do you have any food or environmental allergies? List any food or environmental allergies you experience.

Food/Environmental Allergy	Reaction

If you have food allergies, do you avoid these foods? Yes No

Diet

Shopping,Cooking, and Dining Check all that apply.

Who does the...	Grocery Shopping?	Cooking?	Who do you dine with?
Myself			
My spouse			
My child/children			
My parents			
Additional family members			
Friend/friends			
Institution(e.g. Care home)			

Do you eat alone?
How often?

Some of the time(about 1 meal per week)

Most of the time (at least half of your meals)

All of the time

Where do you eat?
Check all that apply.

At the dinner table

Standing in the kitchen

Watching TV

In the car/commuting

At my desk

Kitchen Appliances

Please select all appliances that you have consistent access to.

- Refrigerator
- Freezer
- Stove
- Oven
- Microwave
- Toaster Oven
- Blender
- Slow Cooker
- Pressure cooker/Instant Pot
- Air Fryer
- Grill
- Spiralizer
- Mixer

Do you use EBT, food stamps, food pantries or other federal aids to obtain your food and groceries? Yes No

Please describe.

Food Frequency

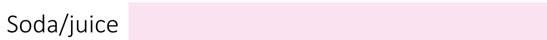
How often do you eat...	Times per day	Times for week
Red Meat		
Poultry		
Seafood		
Plant based proteins		
Eggs		
Dairy		
Heart healthy fats		
Fruits		
Vegetables		
Whole Wheat/Whole Grain		
White Grains/Breads		
Fast food/Dining Out		

How many ounces of water do you drink daily? ______________________________

One standard-sized water bottle is about 16 ounces, or two cups.

Additional Beverages

	Daily	Occasionally	Rarely/Never
Coffee			
Tea			
Soda/juice			
Alcohol			



Do you follow any religious or cultural dietary rules or guidelines? Yes No

Please describe.

Are there any foods that you avoid (not including food allergies)? Yes No

Please explain.

Any history of diets (e.g., Keto, Paleo, Whole 30, Intermittent Fasting, tracking calories or macros)? Yes No

Please list

Do you skip meals? Yes No

Please explain.

Do you honor hunger cues? Yes No

Have you ever restricted calories to lose weight? Yes No

Have you or do you engage in binge eating behaviors? Yes No

Do you engage in stress eating or use food as a coping mechanism? Yes No

What are your favorite foods?

Lifestyle

How many hours do you sleep a night? _______________

Check any/all that may apply

- Trouble falling asleep
- Waking frequently through the night
- Wake feeling unrested

Are you currently exercising? Yes No

Current Exercise Routine

Type of activity	Times per week	Duration per Event(minutes)

Do you enjoy your current exercise routine? Yes No

What role does exercise play in your life (e.g., stress/anxiety relief, weight management, fun, guilt/compensatory)?

Do you use a fitness tracker? Yes No

If yes, what type? ______________________________

What do you do to have fun? What are your hobbies?

How many hours per day do you watch TV? __________

What level of stress are you currently experiencing? ________

1= None at all, or small and well-controlled, 10= An excessive and uncontrollable amount.

List your main stressors

Chemicals

Do you OR have you ever used tobacco products? Yes No

If you quit, what year did you quit? __________

Tobacco product(s) used

- Cigarettes
- Electronic Vaping
- Cigars
- Chewing Tobacco
- Other

How many cigarettes did/do you smoke per day? ____________

For how many years? _____________

Do you OR have you used recreational drugs? Yes No
If yes, please describe.

List your current health concerns in order of importance

What thoughts and feelings come to mind when you think about food?

What about cooking, grocery shopping, or meal preparation?

Have you ever worked one-on-one with a registered dietitian or other nutritional professional before? Yes No
What was their name and professional title? How was your experience with them? What was helpful and what was not helpful? Please provide as much detail as possible.

What do you want to accomplish in our first session together?

What do you need from me to support you on your way to your health goals?

Accountability? Weekly check-ins? Recipes or meal plans? Cooking tips? Community? The more information you share here, the better prepared I'll be to support you.

What is your level of commitment to improving your health? ________________________

1-Lowest, 10-Highest

What challenges may get in your way of following a treatment plan?

What kind of barriers should we expect? This will help us prepare so you can achieve results!