



## Comprehensive Nutrition Intake Form

*Please email your completed form at least **24 hours before our first appointment.**  
(Download and save your completed form then email to [info@synergyfitnessforher.com](mailto:info@synergyfitnessforher.com).)*

### 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

Daily/frequent use of laxatives

Loose stools

Daily/frequent use of stool softeners

Constipation

Diarrhea

Bloating/gas

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My child/children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Additional family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Friend/friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Institution(e.g. Care home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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!