Nutrition Intake Form

Date:_______________

Name:	Date of Birth:	Age:
Address: ___ Street / City / State / Zip		
Contact: ___ Home phone / Cell phone / Work phone / Email		
Occupation/Employer:		
Physician Name & Contact Info (Phone/Address):		
Emergency Contact (Name, Phone, and Relationship):		

Please provide responses below concerning **family history, personal history, and symptoms**:

FAMILY HISTORY
Have any immediate family members had a:

	YES	NO
Heart attack	O	O
Heart surgery	O	O
Coronary stent	O	O
Cardiac catheterization	O	O
Congenital heart defect	O	O
Stroke	O	O
Diabetes	O	O
Thyroid disease	O	O

Other chronic/autoimmune disease:
____
____

PERSONAL HISTORY
Have you ever had:

	YES	NO
High blood pressure	O	O
High cholesterol	O	O
Diabetes	O	O
Any heart problems	O	O
Disease of arteries	O	O
Thyroid disease	O	O
Lung disease	O	O
Asthma	O	O
Cancer	O	O
Kidney Disease	O	O
Hepatitis	O	O

Other: ________________________
____

SYMPTOMS
Have you ever had:

	YES	NO
Chest pain	O	O
Shortness of breath	O	O
Heart palpitations	O	O
Skipped heartbeats	O	O
Heart murmur	O	O
Intermittent leg pain	O	O
Dizziness or fainting	O	O
Fatigue - usual activity	O	O
Snoring	O	O
Back pain	O	O
Orthopedic problems	O	O

Other: ________________________
____

Are you taking any prescription **medications**?	Yes □	No □
Are you taking any non-prescription medications or **nutritional supplements**?	Yes □	No □

If yes to either of the above, please complete the section below for your current medications and/or supplements:

Med/Supp *Dosage – Times/Day* *Time Taken* *Years on Med/Suppl* *Reason for Taking*

____
____
____

Nutrition Intake Form

WEIGHT HISTORY

	Weight Range (approximate)	Comment, if weight changed
Max / Min Adult Weight		
1 year ago		
6 months ago		
Today		

Are you satisfied with your current weight and body composition? Yes □ No □

Nutrition Related Concerns

Within the past 6-months have you experienced any of the following?

Do you have any food allergies or intolerances?	Yes □	No □
Do you experience heart burn / reflux?	Yes □	No □
Do you experience pain when eating?	Yes □	No □
Do you experience nausea / vomiting when eating?	Yes □	No □
Do you experience bloating when eating?	Yes □	No □
Do you experience gas when eating?	Yes □	No □
Do you experience diarrhea when eating?	Yes □	No □
Do you experience constipation when eating?	Yes □	No □
Do you experience difficulty chewing or swallowing when eating?	Yes □	No □
Do you regularly skip meals? If yes, which meal? Please circle: Breakfast Lunch Dinner	Yes □	No □
Do you tend to have significant night time snacking / eating?	Yes □	No □
Do you mindlessly eat (when you're not really hungry, bored, etc.)?	Yes □	No □
Do you emotionally or stress eat?	Yes □	No □
Are you a fast eater? (first to finish a meal)	Yes □	No □
Do you have a negative relationship with food?	Yes □	No □
Do you over eat at meals?	Yes □	No □
Do you have a poor diet when traveling?	Yes □	No □
Does your diet change when busy?	Yes □	No □
Do you dislike healthy foods?	Yes □	No □

Lifestyle Habits

How would you rate your current stress level?	None □	A little □	Moderate □	High □
Do you currently use tobacco products?			Yes □	No □
Do you get at least 7 hours of nightly?			Yes □	No □
Do you perform aerobic exercise? (ie jog, elliptical, spin, sports etc.) If yes, how many times per week ________ and how long each time _______			Yes □	No □

Nutrition Intake Form

Question	Yes	No
Do you perform resistance/strength training? If yes, how many times per week _______ and how long each time ______	Yes □	No □
Do you perform flexibility/ balance training? (including yoga or Pilates) If yes, how many times per week _______ and how long each time ______	Yes □	No □

Eating Patterns

Question	Yes	No
Do you eat at least 3 meals per day?	Yes □	No □
Do you often feel hungry at a particular time of day? If yes, when? Please circle: Morning Afternoon Night	Yes □	No □
Do you drink at least 8 cups of water daily? (1 cup = 8 oz. / Most water bottles = 2 – 3 cups)	Yes □	No □
Do you eat at least 2 servings (1 serving = 1 fistful) of fruit daily?	Yes □	No □
Do you eat at least 3 servings (1 serving = 1 fistful raw, ½ cooked) of vegetables daily?	Yes □	No □
Do you drink more than 5 alcoholic beverages (1 glass, bottle, shot) per week?	Yes □	No □
Do you drink energy drinks?	Yes □	No □
Do you drink juice?	Yes □	No □
Are you interested/do you enjoy cooking?	Yes □	No □
Do you eat breakfast/brunch out or take-out more than 3 times a week	Yes □	No □
Do you lunch out or take-out more than 3 times a week	Yes □	No □
Do you eat dinner out or take-out more than 3 times a week	Yes □	No □

Ensuring Success

Question	Answer
What are 3 personal strengths that will help you reach your goals?	1. 2. 3.
What obstacles do you foresee?	

On a scale of 0 to 10 (0=none, 10=completely)

Question	Score
How motivated are you to achieve your goals?	
How confident are you that you can achieve your goals?	