Nutrition Intake Form

Demographics

Name:		Age:	Ethnicity:
Height:	Weight:	Weight 1 year ago:	Your ideal weight:
Occupation:		Hours of work per week:	

Health Concerns

List your top 3 health concerns (in order of priority) from a nutritional standpoint.

	Problem/Concern	Severity	Treatments Tried	How Successful?
	Ex. Abdominal bloating	*Moderate*	*Eliminating dairy*	*Moderately*
1.				
2.				
3.				

What do you hope to get out of nutritional counseling?

_____

_____

Social Environment

1. Who lives with you? (Ex. children, parents, and/or housemates) Please include ages.

_____

_____

2. Who does the cooking/food prep in the house? How about the grocery shopping?

_____ _____

3. How much do you enjoy cooking? ☐ Alot ☐ Somewhat ☐ Not at all ☐ I don't cook

4. Does anyone in your house have special dietary restrictions that would affect what/how you eat?

☐ Yes ☐ No ☐ N/A

5. How many times on average do you eat out weekly (including takeout)? _____

What restaurants? _____

6. What percent of your diet a) is made from scratch _____

b) from a box/package (ex. microwave meals) _____

▸ ***YOUR DIET:***

BEVERAGES

a) How much **caffeine** do you drink daily (cups of coffee, tea, energy drinks)? _____

b) How many glasses (8 fl oz) of **water** do you typically drink a day? _____

c) How many servings of **alcohol** do you consume daily? _____

What type? ☐ Beer ☐ Wine ☐ Mixed Drinks ☐ Shots ☐ N/A

FOODS

d) Are you currently on a special diet? If so, which one? *(ex. vegan, Paleo, Keto, intermittent fasting, low sodium, etc)*

_____

e) What type of diet have you felt the best on? _____

f) Do you have any allergies/food sensitivities? ☐ Yes ☐ No

To what? (please describe reaction)_____

g) Any foods you hate? ☐ Yes ☐ No If so, which? _____

h) Do you feel ***WORSE*** when you have the following:

_____high fat foods _____ high protein foods _____high starches (*bread, pasta, rice*) _____high sugars

_____alcohol (1-2 drinks) _____caffeine _____gluten _____dairy _____NONE

i) Do you feel ***BETTER*** when you have?

_____high fat foods _____ high protein foods _____high starches _____high sugars

_____alcohol (1-2 drinks) _____caffeine _____gluten _____dairy _____NONE

j) Does skipping meals affect you (ex. Getting shaky, irritable)? ☐ Yes ☐ No

k) Do you have any teeth/gum issues? Check all that apply.

☐ Missing teeth ☐ Dentures ☐ Bridge ☐ Gingivitis

l) In regard to your bowel movements, please circle what applies in each column below.

FREQUENCY	COLOR	CONSISTENCY
> 3x /day	Yellow, Light Brown	Diarrhea
2-3x/day	Medium Brown consistently	Loose but not watery
1x /day	Very Dark or Black	Soft and well-formed
3-4 x/week	Green Colored	Hard to pass
1x/ week	Blood is Visible	Thin, long, and narrow
	Greasy, Shiny	Small and hard
		Alternating hard/loose
		Floating Stools

▸ Other Lifestyle Habits

SLEEP: a) How many hours of sleep do you get a night *(on average)*? _____

STRESS: a) On a scale of 1-10 with 10 being the highest, what is your current stress level? _____

b) What are your biggest stressors? _____

c) How do you manage stress? _____

PHYSICAL ACTIVITY:

How many days a week do you intentionally exercise? _____

How long each time? _____

What kind of physical activity do you do? _____

Medications/supplements

Please list your current Meds/supplements. This includes vitamins, minerals, herbs, probiotics, protein powders and shakes.

Medications:

Name (strength, dose)	Since when?

Supplements:

Name (strength, dose, company)	Since when?

Food Log

*Please complete this food log for 6 consecutive days, with at least one of the days being a weekend day.

* Don't change your eating behavior unless you have been told to. The purpose of this food record is to analyze your current eating habits, not what it should be.

*Please be as descriptive as possible (ex., milk - what kind? (whole, 2%, or nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded), etc.

*Record the amount of food consumed with measurements, Ex. 8 oz, 1/2 cup, 1 teaspoon, etc.

*Include added items. (Ex: tea with 1 tsp sugar, potato with 2 teaspoons butter, etc.)

*Please record all beverages, including water.

	DAY 1	DAY 2	DAY 3
Wake up time?			
BREAKFAST			
Snacks			
LUNCH			
Snacks			
DINNER			
Snacks/ Desserts			
Sleeping time?			

	DAY 4	DAY 5	DAY 6
Wake up time?			
BREAKFAST			
Snacks			
LUNCH			
Snacks			
DINNER			
Snacks/ Desserts			
Sleeping time?			