



Nutritional Consultation Intake for Existing Patients

PATIENT INFORMATION

Full Name: _____ Date: _____
Day/Month/Year

CONTEXT OF CARE

1. Why are you interested in a nutritional consultation and/or menu plan?

2. What expectations or desired outcomes do you have from working with me?

3. What is your present level of commitment to changing your diet and lifestyle to a healthier one? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

4. Please describe your current approach to diet and nutrition (i.e. junk food junkie, committed vegetarian, eat out most meals, love to cook, ready to learn...etc):

6. What obstacles do you face in achieving your health and nutrition goals?

MEDICAL HISTORY

Please list your chief health concerns and/or any conditions you currently suffer from:

| Concern | Since |
|---------|-------|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

MEDICATIONS / SUPPLEMENTS / DRUGS

Please list all **current** medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

| Drug / Supplement (Company & Brand Name) | Used For | Date Started | Dosage / Frequency |
|--|----------|--------------|--------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

ALLERGIES, SENSITIVITIES, EXPOSURES

Please list any known or suspected food allergies, sensitivities and/or intolerances:

WEIGHT

Height: _____ Current Weight: _____ Desired weight if different? _____
 Maximum weight? _____ When? _____
 Minimum weight? _____ When? _____
 Have you gained or lost any weight in the past 6-12 months? Y N
 If so, how much? _____ Gained or lost? _____ Was this intentional? _____

DIET & DIGESTION

Are there any foods you avoid or exclude from your diet? If so, for what reason?

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)

What are your favourite foods?

Check all of the following items that you currently eat:

- lentils & beans
- poultry
- eggs
- at least 2 servings fresh fruits per day
- at least 4 servings (1 cup raw/1/2 cup cooked) veggies per day
- bread, baked goods, pasta, cereal or crackers daily
- soy
- pork
- avoid gluten
- fish
- beef
- nuts
- seafood/shellfish
- dairy
- seeds
- brown rice, barley, quinoa, other whole grains

Which of the following do you like most?

- spicy
- crunchy foods
- fresh salads
- variety of ethnic foods
- sweet
- soft foods
- soups & stews
- continental/North American fare
- salty/savoury
- creamy foods
- pasta
- sour flavour
- chewy foods
- meat & potatoes
- fast food / fried food
- bitter flavour
- sandwich

Do you regularly eat breakfast?

Do you prepare your own lunch or eat out?

How many nights per week do you cook dinner?

How many nights per week do you eat out/order in?

What is your current skill level and interest level in cooking and food preparation?

Is there any more information you'd like to provide me with to better customize your meal plan?

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?

What other beverages do you drink, and how much?

How often do you urinate? Every ____ hr(s)

How often do you have a bowel movement (per day or week)?

LIFESTYLE FACTORS

Please fill out the schedule below. For a highly variable schedule enter in the parts that recur and enter “variable” in the other sections. For events that recur weekly, enter as “yoga class Mon & Fri”.

| | Typical Weekday | Typical Weekend Day |
|-----------------|-----------------|---------------------|
| 5:00-5:30 am | | |
| 5:30-6:00 am | | |
| 6:00-6:30 am | | |
| 6:30-7:00 am | | |
| 7:00-7:30 am | | |
| 7:30-8:00 am | | |
| 8:00-8:30 am | | |
| 8:30-9:00 am | | |
| 9:00-9:30 am | | |
| 9:30-10:00 am | | |
| 10:00-10:30 am | | |
| 10:30-11:00 am | | |
| 11:00-11:30 am | | |
| 11:30am-12:00pm | | |
| 12:00-12:30 pm | | |
| 12:30-1:00 pm | | |
| 1:00-1:30 pm | | |
| 1:30-2:00 pm | | |
| 2:00-2:30 pm | | |
| 2:30-3:00 pm | | |
| 3:00-3:30 pm | | |
| 3:30-4:00 pm | | |
| 4:00-4:30 pm | | |
| 4:30-5:00 pm | | |
| 5:00-5:30 pm | | |
| 5:30-6:00 pm | | |
| 6:00-6:30 pm | | |
| 6:30-7:00 pm | | |
| 7:00-7:30 pm | | |
| 7:30-8:00 pm | | |
| 8:00-8:30 pm | | |
| 8:30-9:00 pm | | |
| 9:00-9:30 pm | | |
| 9:30-10:00 pm | | |
| 10:00-10:30 pm | | |
| 10:30-11:00 pm | | |
| 11:00-11:30 pm | | |
| 11:30pm –12am | | |
| 12:00-12:30 am | | |
| 12:30-1:00 am | | |
| 1:00-1:30 am | | |
| 1:30-2:00 am | | |
| 2:00-2:30 am | | |
| 2:30-3:00 am | | |
| 3:00-3:30 am | | |
| 3:30-4:00 am | | |
| 4:00-4:30 am | | |
| 4:30-5:00 am | | |

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?

What other beverages do you drink, and how much?

How often do you urinate? Every _____ hr(s)

How often do you have a bowel movement (per day or week)?

Do you suffer from any digestive problems (diarrhea/constipation, heart burn, reflux, IBS, IBD, etc)?

What is your current level of activity?

Please describe what activities you currently engage in regularly, the frequency, duration and intensity:

Thank you for taking the time to complete this intake form. It's completion will help me to understand your whole health picture, and your nutritional needs and goals. Please complete the diet diary on the following page.

Diet Diary

Name: _____

Please provide a **detailed** account of all food, beverages, condiments and snacks consumed, including **portion sizes** and **times** consumed. Provide 2-3 typical weekdays and 1 typical weekend days. Also note whether food was **purchased, eaten out or prepared at home**.

| | Weekday 1 | Weekday 2 | Weekday 3 | Weekend 1 |
|--|-----------|-----------|-----------|-----------|
| Date: | | | | |
| Breakfast | | | | |
| Lunch | | | | |
| Dinner | | | | |
| Snacks Water Beverages Medications Supplements | | | | |
| Comments: Symptoms Energy level Mood Digestion Bowel Movements Headache | | | | |