Client Nutritional Intake

Personal Information

Name: ____ Today's Date: __________

Address: ______________________________ City: _________ ST: ____ ZIP:_________

Phone Number: __________________ Email: _________________________________

Date of Birth: _________________ Height: __________ Weight _________ Male - Female

Occupation: ___________________________________

Personal Medical History

Primary Care Physician: ______________________________ Phone #: _____________

Please list all surgeries: ____

____

Please list hospitalizations, and why:

____

____

Family Medical History

Do you or anyone in your immediate family have a history of the following:

	Self	Relative
Allergies (air-born)	□	□
Allergies (food)	□	□
Anxiety	□	□
Auto-Immune Disease. *Please be specific*	□	□
Cancer	□	□
Diabetes	□	□
Heart Disease	□	□

High Blood Pressure	☐	☐
High Cholesterol	☐	☐
Inflammatory Bowel Disease (IBS)	☐	☐
Insomnia	☐	☐

Current Medical Information

Please list all prescription medications, and reason for each.

____
____

Please list all supplements, and reason for each.

____
____

Are you currently pregnant? **Y** **N** If yes, due date: ____________________

Have you ever been pregnant? **Y** **N**

How many children do you have? _____________

What are the ages of your children? ____

Do you smoke? **Y** **N** If yes, how much? _______________ How many years? _________

If no, have you ever smoked? ______ How many years? _________

Do you drink alcohol? **Y** **N** If yes, how frequently? _____________________________

Are you a coffee drinker? **Y** **N** How many cups daily? _____________

What is the main reason you are here today?

____
____

What is your ultimate health goal? Please be detailed.

____
____
____

What is your most challenging health issue?

____

____

Do you exercise? **Y** **N** What type of exercise? ________________________________

Frequency __________

How many hours of sleep do you generally get nightly? ___________________

Please list the meals you have eaten over the past 72 hours (3 days).

Today	Yesterday	The Day Before Yesterday
Breakfast	Breakfast	Breakfast
Lunch	Lunch	Lunch
Dinner	Dinner	Dinner

How many servings of whole fruits do you consume daily? ____________

List most common fruits you consume. ____

How many servings of vegetables do you consume daily? _____________

List most common vegetables you consume. ____

Please list any foods which cause digestive issues? ___________________________________

____

Do you prepare most meals at home? **Y** **N**

If not, which meals do you generally eat out? ____

How often, per week, do you eat at restaurants or fast food establishments?________________

How many hours before bed do you stop eating / snacking? ________________

Do you prefer **gluten free**, **vegetarian**, **vegan**, **dairy free**, **heart healthy** (please circle)

Are you ready to track your daily meals in a food journal or food tracking app? **Y** **N**

Are you ready to create and engage in an exercise regimen? **Y** **N**

Are you ready to participate in meditation or stress reduction exercises? **Y** **N**

I, ________________(client name)______________________ agree to work with my nutrition and wellness coach to co-create a healthier lifestyle. I understand that my coach is here to guide me on my journey; however, it is my responsibility to take action for my new healthy lifestyle.